S. HRG. 99-342

ECONOMIC PROBLEMS FACING HOSPITALS SERVING THE POOR AND ELDERLY

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

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HOSPITALS SERVING THE POOR AND ELDERLY

MONDAY, JULY 29, 1985

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, DC.

The committee met, pursuant to notice, at 1:35 p.m., in room SD-215, Dirksen Senate Office Building, Hon. David Durenberger (chairman) presiding.

Present: Senators Heinz, Durenberger, Symms, and Baucus.

[The press release announcing the hearing, the background paper prepared for the Finance Committee, and the opening statements from Senators Heinz and Mitchell, follow:]

[Press Release No. 85-054]

COMMITTEE ON FINANCE SETS HEARING ON HOSPITALS SERVING THE POOR AND ELDERLY

The Senate Committee on Finance's Subcommittee on Health has scheduled a July 29, 1985, hearing to consider the economic challenge that may be facing American hospitals treating a disporportionately large number of low income patients, committee Chairman Bob Packwood (R-Oregon) announced today.

Senator Packwood said the Subcommittee on Health hearing would begin at 1:30 p.m., Monday, July 29, 1985, in Room SD-215 of the Dirksen Senate Office Building in Washington.

Senator Dave Durenberger (R-Minnesota), chairman of the Subcommittee on Health, wil preside at the hearing.

Specifically, the Subcommittee on Health will examine the progress being made in understanding the factors associated with U.S. hospitals which treat a disproportionately large number of low income and Medicare patients, Senator Packwood said.

"We want to take a good look at the progress which has been made in understanding what causes the higher costs that are experienced by hospitals treating the poor," Packwood said.

"We would hope that this hearing on July 29 will provide us with a solid record on which we can make a judgment on the adequacy of the Medicare reimbursement policy now in place for such hospitals—and if that policy needs to be altered and, if so, in what manner," the Chairman added.

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MEDICARE PAYMENT PROVISIONS FOR DISPROPORTIONATE SHARE HOSPITALS

Background Paper

Prepared for the Use of the Members of
the Committee on Finance

July 1985

I. INTRODUCTION

Since 1982, legislation enacted to reform Medicare's method of making payments to hospitals has contained a provision for the special treatment of hospitals serving a significantly disproportionate number of patients who have low income or are entitled to benefits under Part A of Medicare. Section 1886(d)(5)(C)(i) of the Social Security Act states that the Secretary of Health and Human Services . . . "shall provide for such exceptions and adjustments to the payment amounts established under this subsection as the Secretary deems appropriate to take into account the special needs of . . . public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this title."

The Secretary, however, has not provided for a "disproportionate share" adjustment to hospital payments made under Medicare's Prospective Payment System. There are a number of reasons why this provision is considered to be troublesome to implement:

1. Ambiguity in the wording of the law. Some believe that the language of the provision is not clear, leading to questions such as:

   --whether the Secretary is required to provide a disproportionate share adjustment, using her discretion to determine the nature of the adjustment;

   --whether the Secretary is required to provide such an adjustment if she finds that an adjustment is needed by such hospitals; or

   --whether the Secretary is merely authorized to provide the adjustment at her discretion.

This ambiguity has led some to believe that, despite Congressional mandate, the Health Care Financing Administration (HCFA, which administers the Medicare program) is reluctant to implement the provision. HCFA, on the other hand, has stated that it will not implement the provision until it finds evidence that hospitals serving a disproportionate number of low income or Medicare Part A patients incur higher Medicare costs per case. A 1984 decision by the U.S. District Court for the Northern District of California ordering HCFA to implement the disproportionate share provision also illustrates that the intent of the provision is still open to interpretation.

2. Problems with identifying disproportionate share hospitals. The language of the provision does not specify those hospitals which should receive the adjustment or how the hospitals should be identified. Research on this issue has been concerned with the following questions.

--What are the "special needs" of hospitals serving a significantly disproportionate number of low income or Medicare Part A patients?

--What data are available to define low income or Medicare Part A patients?

--What threshold should be used to determine if a hospital has a "disproportionate number" of such patients?

3. Determining the nature of the payment adjustment. Once the definition of a disproportionate share hospital has been determined, the nature of the payment adjustment for such hospitals must be decided. A difficult problem in this decision is to insure that such hospitals are not already being paid under the Prospective Payment System (either through the payment rates themselves

or through certain other additional payments, such as the indirect medical education adjustment) for the same costs that the disproportionate share provision attempts to address.

This document has been prepared to (1) review the history of the provision, including recent legal and legislative activity; (2) summarize the research findings; and (3) discuss the issues involved in implementing the disproportionate share provision.

II. HISTORY OF MEDICARE PAYMENT PROVISIONS FOR "DISPROPORTIONATE SHARE" HOSPITALS

A. Overview

Legislation addressing "disproportionate share" hospitals (DSHs) was first enacted as a provision in the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248). The Secretary of Health and Human Services was required to provide for exemptions from, and exceptions and adjustments to, the limits then in effect under Medicare's former method of cost-based hospital reimbursement which the Secretary deemed were appropriate to take into account the special needs of DSHs. However, the Health Care Financing Administration (HCFA, which administers the Medicare program) did not implement this provision because, as was indicated in regulations, it did not at that time have data to determine the extent to which special consideration for such hospitals was warranted or the type of provision that might be appropriate.

A similar provision for DSHs was included in P.L. 98-21 (the Social Security Amendments of 1983) as an adjustment to the payment rates under the new Medicare hospital payment method, the Prospective Payment System (PPS). HCFA indicated in regulations that it would not implement the DSH provision in FY84 and FY85 because, although the issue was being studied, HCFA did not have evidence justifying the need for the adjustment. P.L. 98-369 (the Deficit Reduction Act of 1984) required the Secretary of Health and Human Services (HHS) to develop a definition of "disproportionate share" hospitals and to identify such hospitals by December 31, 1984. HCFA is currently working on meeting this requirement.

On April 1, 1985, the Prospective Payment Assessment Commission, which was mandated by P.L. 98-21 to advise the Secretary and Congress on PPS issues, recommended that a DSH adjustment be included in the FY86 PPS rates. When HCFA published proposed regulations on June 10, 1985, a DSH provision was not included. However, in response to a court order from the U.S. District Court for the Northern District of California, HCFA published proposed rules implementing the DSH provision on July 1, 1985.

On July 15, 1985, the Subcommittee on Health, House Ways and Means Committee, approved a number of changes to the Medicare program for FY86. Included was a provision to require the Secretary to make additional payments under PPS to urban hospitals with 100 or more beds serving a disproportionate share of low income patients.

B. P.L. 97-248, the Tax Equity and Fiscal Responsibility Act of 1982

Enacted legislation specifically mentioning "disproportionate share" hospitals (DSHs) first appeared in TEFRA, the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248; September 3, 1982). Title I, Section 101(a)(2)(B), of P.L. 97-248 provides a new Section 1886(a)(2)(B) of the Social Security Act, which states that "The Secretary shall provide for such exemptions from, and exceptions and adjustments to, the limitation established under paragraph (1)(A) as he deems appropriate, including those which he deems necessary to take into account- . . . (B) the special needs of . . . public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this title" . . . . Essentially, this provision requires the Secretary of Health and Human Services, as the Secretary considers appropriate, to provide adjustments to the limits placed on Medicare reimbursement to hospitals, including those that the Secretary

determines are necessary to address the special needs of hospitals serving a comparatively large number of poor or Medicare Part A patients.

The earlier versions of this provision as reported by the House and Senate committees of jurisdiction were different from one another. Section 110(a) of H.R. 4961, as reported by the Senate Finance Committee on July 12, 1982, stated that "The Secretary may provide for exemptions, exception, and adjustments to the limitation established under paragraph (1)(A) as he deems appropriate, including those which he deems necessary to take into account the special needs of . . . hospitals which incur additional costs in treating low income patients." This language differed from the final enacted provision in that the Secretary was authorized, not required, to include adjustments as the Secretary deemed were necessary; public hospitals were not specifically mentioned; the adjustment was allowed only for hospitals that incurred additional costs; the criterion for receiving the adjustment was based on the hospital's low-income patients only, not patients entitled to Part A benefits; and the hospital did not have to have a disproportionate share of such patients.

The Senate report language (S. Rept. 97-494, Vol I; July 12, 1982) stated that "The Secretary is directed to determine the extent to which the new hospital reimbursement limits for certain public hospitals and other institutions including public benefit corporations, should be adjusted to take into account the extra costs that they incur in treating low-income patients."

Although not formally approved and reported by the Ways and Means Committee, Section 111(a)(1) of H.R. 6878 (which embodied the tentative decisions made by the Committee on July 15, 1982) included a DSH provision very similar to the final enacted version.

When the Health Care Financing Administration (HCFA) issued interim final regulations implementing Section 101 of TEFRA on September 30, 1982, it indicated

(at 47 FR 43285) that exemptions or exceptions were not included for disproportionate share hospitals. HCFA's rationale was that it did not have data to enable it to determine the extent to which special consideration for such hospitals was warranted or the type of provision that might be appropriate. HCFA did indicate that it would examine the issue further and, if it were found that such an adjustment was warranted, the regulations would be revised. 1/

In final regulations implementing Section 101 of TEFRA, issued August 30, 1983, HCFA again stated (at 48 FR 39429) that it had not been able to demonstrate empirically that public hospitals as a group incur additional costs because they treat a disproportionate number of low income or Medicare Part A patients. HCFA indicated that it had consulted with representatives from the health care field and had arranged for a review of available data, which was still in progress. If a DSH adjustment were warranted, HCFA indicated it would be provided in future regulations.

C. P.L. 98-21, the Social Security Amendments of 1983

In 1983, legislation was enacted changing Medicare's method of hospital payment from the former cost-based system with limits to a new Prospective Payment System (PPS), under which hospitals are paid a fixed payment rate per case (patient) for cases classified according to diagnosis into one of 468 categories called Diagnosis Related Groups (DRGs). Hospitals not included under PPS (such as long-term care hospitals, rehabilitation hospitals, psychiatric hospitals, etc.) would continue to be paid on the basis of allowable incurred costs subject to the rate of increase limits imposed by TEFRA.

1/ See Section III. below for a discussion of HCFA's research on this issue.

The statute authorizing the change to PPS included an exception for disproportionate share hospitals. P.L. 98-21 (the Social Security Amendments of 1983, enacted April 20, 1983) included in Section 601(e) a new Section 1886(d)(5)(C)(i) of the Social Security Act which states that "The Secretary shall provide for such exceptions and adjustments to the payment amount established under this subsection as the Secretary deems appropriate to take into account the special needs of . . . public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this title." This is essentially the same language as enacted in TEFRA, although the TEFRA legislation provides for an adjustment to limits on the former cost-based method of reimbursement, while P.L. 98-21 provides for an adjustment to the prospective payment rates.

House and Senate reported versions of this legislation (H.R. 1900 and S. 1) contained the same DSH language as P.L. 98-21. The Ways and Means Committee report on H.R. 1900 (Rept. 98-25, Part 1; March 4, 1983) reflected the Committee's concern that the patients in DSHs may be more severely ill than average, which may not be adequately reflected in the diagnosis-related payment rate under PPS. The report urged the Secretary to continue to study ways of taking account of severity of illness in the payment system, and if DSHs needed adjustments due to severity of illness or other needs, the Secretary was authorized to provide them.

The Finance Committee report on S. 1 (Rept. 98-23; March 11, 1983) expressed concern that public hospitals and other hospitals that serve a disproportionately large number of low income and Part A Medicare beneficiaries may serve patients who are more severely ill than average and that the DRG payment system may not adequately take into account such factors. The Committee report noted that the

Secretary had stated that the Department of Health and Human Services would continue to study ways of taking account of severity of illness in the DRG system.

None of the regulations implementing the Prospective Payment System (PPS) have included an adjustment for DSHs. The FY84 PPS regulations (interim final regulations issued September 1, 1983, at 48 FR 39783, and final regulations issued January 3, 1984, at 49 FR 276) stated that no provision was being made for DSHs because the current HCFA data did not show that such an adjustment was warranted. The FY85 PPS regulations (proposed regulations issued July 3, 1984, and final regulations issued August 31, 1984) did not mention an adjustment for DSHs.

D. P.L. 98-369, the Deficit Reduction Act of 1984

P.L. 98-369 (the Deficit Reduction Act of 1984, or DEFRA; enacted July 18, 1984) included in Section 2315(h) a requirement that prior to December 31, 1984, the Secretary must (1) develop and publish a definition of a "hospital that serves a significantly disproportionate number of patients who have low income or are entitled to benefits under part A" and (2) identify the hospitals meeting that definition and make that identification available to the Committee on Finance and the Committee on Ways and Means.

The Conference Report on DEFRA (House Rept. 98-861; June 23, 1984) states that the Department is required to identify DSH hospitals "so that a better determination can be made under existing law as to whether payment exceptions or adjustments are appropriate." The report indicates that this provision reflected the conferees' concern about the potentially harmful impact of PPS on DSHs. The report also recalls that the Congressional reports for the original 1983 PPS legislation expressed concern that such hospitals may serve patients

who are more severely ill than average, a factor which the DRG payment system may not take into account. The report expresses the conferees' concern about the adequacy of the efforts made by the Secretary to determine whether a DSH exception or adjustment is needed and specifically mentions that no effort has been made to develop a definition of DSHs so that any special needs they have could be assessed.

Although several other PPS changes made as a result of DEFRA were mentioned in final FY85 PPS regulations issued August 31, 1984 (49 FR 34727), the DSH provision in DEFRA was not discussed.

The proposed FY86 PPS regulations issued June 10, 1985 (50 FR 24384) raised the issue of an adjustment for DSHs. In the context of a discussion of various PPS recommendations made to the Secretary by the Prospective Payment Assessment Commission (see Section E below for more detail), HCFA stated that, as required by DEFRA, it has been working on a definition of DSHs. However, HCFA indicated that lack of data has hampered its efforts. It cited problems with its own research and that conducted by other organizations. 2/ HCFA said that once it obtains accurate data, it will try to determine whether DSHs experience higher Medicare costs per case due to the provision of care to low income or Medicare Part A patients, and if these additional costs are accounted for by such factors as severity of illness or inefficiency. HCFA stated that it will then determine if these costs are already recognized in the PPS payment or if a payment adjustment should be made.

2/ See Section III. below for a discussion of the research on this issue.

E. Recommendations of the Prospective Payment Assessment Commission

The 1983 legislation which authorized Medicare's new Prospective Payment System (P.L. 98-21) required the appointment of a commission known as the Prospective Payment Assessment Commission, or ProPAC. Among other duties, ProPAC is required to report to the Secretary by April 1 each year (beginning in 1985) its recommendations on the PPS payment levels and other features of the system. ProPAC included two recommendations for DSHs in its April 1, 1985 Report and Recommendations to the Secretary, U.S. Department of Health and Human Services.

Recommendation 14 stated that the Secretary should develop a methodology for a DSH adjustment to the PPS rates and implement the adjustment so that it does not change aggregate payments. Recommendation 15 stated that the Secretary should complete the development of a definition of DSHs so that an adjustment could be made beginning in FY86. The ProPAC report states that Congress has made it clear that PPS payment adjustments should be made for hospitals that incur higher Medicare costs per case associated with treating a high proportion of low income or Medicare Part A patients, if such costs are not accounted for in the PPS payment methodology. ProPAC indicated that it is convinced, after its review of the studies, that DSHs do incur higher Medicare costs per case for reasons such as their volume of Medicaid cases. Although ProPAC believes that the precise reasons for these higher costs are unknown, the costs are due to factors beyond the control of DSHs and should thus be paid by Medicare through an adjustment to the PPS rates.

ProPAC recommended that HCFA separate the effects of serving a low income population from other factors already reflected in the PPS rates, such as those compensated for by the indirect teaching adjustment. Also, any underpayments

to DSHs due to the current definition of labor market areas or inadequate measures of severity of illness should be taken into account. ProPAC recommended a graduated schedule of adjustments rather than a single adjustment for hospitals above a certain threshold.

As mentioned in the previous section, HCFA did not provide for a DSH adjustment in its proposed FY86 PPS rates, dated June 10, 1985.

F. Redbud Hospital District v. Heckler

In 1984, a case was heard in the U.S. District Court for the Northern District of California concerning Redbud Hospital's challenge to its initial PPS payment rate (Redbud Hospital District v. Heckler, No. C-84-4382-MHP). Redbud is a 40-bed rural hospital (designated a "sole community hospital" by HCFA), 60% of whose patients are Medicare beneficiaries and an additional 20% are low income Medicaid beneficiaries. Redbud added an intensive care unit and a pharmacy to its existing facility after its base year under PPS had ended. HCFA denied an adjustment to the hospital-specific portion of Redbud's PPS rate to account for the added costs. The hospital argued that without an adjustment it would be forced into default and would not exist in its present form at the time HCFA indicated it could be considered for a retroactive adjustment.

On July 30, 1984, the court granted a preliminary injunction, enjoining the Secretary from imposing PPS on the hospital or reducing the hospital's current level of reimbursement until its base year costs were reconsidered and until the Secretary complied with the issuance of regulations as ordered by the court. In its statement, the court noted that Redbud's status as a hospital serving a disproportionate number of Medicare and Medicaid patients placed it in a class singled out for special consideration by Congress. The court indicated

that "The Secretary was not given the discretion to decide whether such hospitals have special needs; she was given discretion only to decide how best to cope with those special needs Congress had already declared to exist."

The court required the Secretary to promulgate regulations or written policies that take into account the special needs of hospitals serving a disproportionate number of Medicare and low-income patients, as provided in law. On June 14, 1985, the court modified the preliminary injunction to require that the Secretary publish interim final rules in the Federal Register by July 1, 1985, with an effective date of August 1, 1985; a 45-day comment period was required, with final rules to be published no later than October 1, 1985.

Although HCFA is appealing the decision, it published interim rules on July 1, 1985 (at 50 FR 27207) to comply with the court's order. HCFA indicated that the rules would be null and void if a stay of the June 14, 1985 order is granted or if the order is reversed on appeal.

In the portion of the regulations pertaining to DSHs, HCFA stated that the law authorizes "discretionary" adjustments for such hospitals and repeated its earlier statement that it has not made such an adjustment because its current data do not show that it is warranted. However, to comply with the court's order, the interim regulations allow hospitals, on a case-by-case basis, to apply for DSH status. To qualify, a hospital must document:

(1) that it serves a significantly disproportionate number of low income or Medicare Part A patients compared to other Medicare-participating hospitals;

(2) that the special needs of these patients have resulted in additional costs to the hospital, costs that were essential to the provision of care to Medicare beneficiaries (the hospital must include its Medicare cost report for the fiscal period at issue);

(3) the amount of the additional costs that have not been reimbursed adequately under the hospital's PPS rate, indirect medical education, outlier, and other payments; and

(4) that the hospital has instituted revenue collection efforts and cost containment efforts to keep costs within reasonable proximity of the PPS rates.

A hospital's submittal will be sent to the intermediary for analysis and recommendation and then will be sent to HCFA to determine whether a payment adjustment is warranted and, if so, the amount of the adjustment.

G. FY86 Medicare Budget Activity by the House Ways and Means Subcommittee on Health

On July 15, 1985, the Subcommittee on Health of the House Ways and Means Committee approved for full committee consideration certain changes to the Medicare program for FY86. One recommendation would require the Secretary to make additional payments under PPS to urban hospitals with 100 or more beds serving a disproportionate share of low income patients. The proxy measure for low income would be the percentage of a hospital's total patients days attributable to Medicaid patients, including those eligible for both Medicare and Medicaid (known as dual eligibles).

The Federal DRG portion of each PPS payment to the hospital would be increased by 7 percent for each 10 percentage point increase in the proportion of the hospital's low income days to total days, above a minimum threshold of 15 percent. The maximum adjustment could not exceed 16 percent. A limited exceptions process would be established for urban hospitals with 100 or more beds. The Secretary would be required to make disproportionate share payments of 16 percent per DRG payment where a hospital can demonstrate that 35 percent

of its revenue is provided by local or State governments for patient care for low income patients not covered by the Medicaid program. The provision would expire in two years.

III. RESEARCH ON DISPROPORTIONATE SHARE HOSPITALS

This section describes the evidence from research on the relationship between the amount of care hospitals provide to low income and Medicare patients and the level of hospitals' Medicare operating cost per case. Some observers have argued that factors associated with the provision of care to these patients may increase hospitals' costs, and that hospitals serving a disproportionate share of these cases should receive special treatment under PPS. Factors that are hypothesized to increase costs include greater medical needs of these cases (higher severity of illness within DRGs and greater likelihood of complicating conditions, such as alcoholism), greater patient need for social services (counseling, foreign language translation, and discharge planning), and additional costs associated with the location of disproportionate share hospitals in low income urban centers (higher security costs, insurance, and wages).

The research on this issue can generally be considered as falling into three separate phases. The first phase includes research conducted by HCFA which failed to find evidence of any substantial relationship between the amount of care provided to low income and Medicare patients and hospitals' allowed Medicare cost per case. This research provided the basis for HCFA's decision not to incorporate an adjustment for disproportionate share hospitals in the FY84 and FY85 PPS payment rates.

The second phase includes studies undertaken by the American Hospital Association (AHA), and the District of Columbia Hospital Association (DCHA). While based on different data bases and definitions of the amount of care

provided to low income and Medicare patients, both studies found a positive relationship between the percentage of a hospital's patients who are poor and the hospital's Medicare operating cost per case.

The third phase of research is currently underway and includes research being conducted by HCFA, AHA, the Congressional Budget Office (CBO), and the Prospective Payment Assessment Commission (ProPAC). This research includes follow-up studies of alternative measures of the proportion of a hospital's patients that have low incomes, and research examining more carefully the relationship between these measures and Medicare operating cost per case.

A. Phase I: The HCFA Studies

Over the past several years, HCFA has conducted studies exploring the relationship between the amount of care provided to poor and Medicare patients and hospitals' Medicare cost per case. The results of these studies have been used by HCFA as the basis for their decision not to include a disproportionate share adjustment in the PPS. These studies have never been published or presented in final form. This summary of the results of this research is based primarily on statements made by HCFA about the findings as published in the Federal Register at various times over the past three years.

In 1982, HCFA cited research conducted by Applied Management Sciences (47 FR 43285). This study found that Medicare patients use fewer non-routine care resources per hospital day than do non-Medicare patients, and that hospitals with high rates of Medicare utilization have lower routine per diem costs.

HCFA has also conducted its own analyses of Medicare data. As reported in 1984 (49 FR 276), these analyses were based on four sources of data: 1) the 1980 Medicare Cost Reports, used to measure hospitals' Medicare operating cost

per case; 2) 1980 MEDPAR file (a file of a 20% sample of Medicare discharges), used to estimate hospitals' case mix; 3) data from the Bureau of Labor Statistics (BLS) used to construct a wage index; and 4) data from a survey of hospitals, conducted by the Office of Civil Rights, used to determine the distribution of patients in hospitals by race and source of payment during a two-week period. These data were analyzed to determine the extent to which various hospital characteristics, including the amount of care provided to low income patients, were related to hospitals' Medicare cost per case. According to HCFA, these analyses did not find a significant relationship between Medicare costs per case and either public ownership of hospitals, the proportion of Medicaid patients treated by a hospital, or the volume of Medicare cases.

Some have criticized this study on the grounds of inadequate data. While HCFA based its analysis on the only data available at that time, the data used to measure the volume of care provided to low income patients was based on survey data from only a two-week period. In addition, the case mix adjustment was based on 1980 data which was unable to accurately measure either case mix (due to missing data elements) or severity variations within DRGs. While HCFA has acknowledged the data limitations of its analysis, it has argued that based on the currently available information, there is no evidence to support the need for a disproportionate share adjustment.

HCFA has also conducted an analysis comparing Medicare services provided by large urban public hospitals to Medicare services provided by other large urban hospitals (49 FR 276). According to HCFA, the preliminary results from this analysis suggest that, when compared to large urban private hospitals, large urban public hospitals have shorter average lengths of stay for Medicare patients and have fewer Medicare "long stay" cases (using several definitions of long stay cases), but serve more Medicaid cases.

B. Phase II: The AHA and DCHA Studies

The AHA study began as an attempt to replicate HCFA's results. 3/ The analysis was based on pre-PPS hospital level data drawn from the 1980 and 1981 Medicare Hospital Cost Reports, the AHA Annual Survey data (a survey of AHA member hospitals conducted by the AHA), and area wage index and hospital case mix data published in the Federal Register. The sample included 2,400 hospitals for 1980 and 2,700 hospitals for 1981 from a universe of over 5,000 hospitals. The samples included all PPS hospitals for which the AHA could estimate or obtain complete data. It should be noted that large hospitals and hospitals in the Middle Atlantic and East North Central regions were somewhat over-represented in this sample.

The analysis was based on the estimation of a series of multiple regression models. The analysis explored the relationship between Medicare operating cost per case and the share of inpatient services provided to low income and Medicare patients, controlling for the effects of the PPS pricing variables (case mix, area wage index, and the ratio of interns and residents to beds), hospital bedsize and ownership, and size of urban area (small, medium and large) for urban hospitals. The results of the regression analyses (conducted separately for 1980 and 1981 data but yielding consistent findings across years) suggest the existence of a "disproportionate share" effect on hospitals' cost per case. That is, after controlling for the effects of the PPS pricing variables, hospital bedsize, and ownership, hospitals providing higher proportions of services to low income or Medicare patients (whether measured as

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3/ As with the HCFA study, the AHA study has not been published. This description of the AHA study is based on a November 28, 1984 document prepared by the Office of Public Policy Analysis, American Hospital Association, titled "Medicare PPS Equity Adjustments: An Analysis of Medicare/Low-income Patient Involvement and Other Hospital Factors; Attachment A."

percentages of patient revenues or patient days) had higher Medicare operating costs per case.

The study conducted by DCHA differs from the other research in both its focus and scope. 4/ The primary focus of this study was potential inadequacies in the wage index used to adjust PPS payment rates to reflect geographic variations in labor costs. The PPS wage index values for urban hospitals are uniformly defined over metropolitan statistical areas (MSAs) that include both central city and suburban counties. The primary hypotheses of this study were that hospitals located in the central core of urban areas have higher costs than hospitals located in the suburban rings of urban areas, and that these costs should be recognized within the PPS through implementation of an alternative form of the wage index that disaggregates the core and ring areas. According to DCHA, one explanation of why core hospitals may have higher costs is that they serve a disproportionate share of low income patients. Thus, this study presents findings relevant to the disproportionate share issue.

The DCHA study was based on 1981 data for 260 hospitals located in five large metropolitan areas. As noted by the author of this report, the restricted nature of this sample is one limitation of this research. The analysis used a multiple regression model to test for relationships between Medicare operating cost per case and both location in a core area and the percent of care provided to low income patients (Medicaid days as a proportion of total days), controlling for PPS payment variables (case mix, wage index, and ratio of interns and residents to beds). Variables based on Medicare days and hospital occupancy were also examined, but were not found to have a significant relationship to Medicare operating cost per case in all of the models estimated.

4/ Ashby, J. L., Jr., The inequity of Medicare prospective payment in large, urban areas, District of Columbia Hospital Association, September 1984.

The results of this study suggest that, within this limited sample of hospitals, both location in the core of an urban area and the proportion of a hospital's care accounted for by Medicaid patients are positively and significantly related to Medicare operating cost per case for urban hospitals. That is, after controlling for the effects of all other variables, core area hospitals have higher Medicare operating costs per case than ring hospitals, and hospitals treating a disproportionate share of Medicaid patients have higher Medicare operating costs per case than hospitals treating smaller proportions of such patients. The analysis of the DCHA also suggests that the effects of the location and Medicaid days variables on Medicare cost per case overlap to some extent.

C. Phase III: Current Research Efforts

Organizations currently conducting research on the disproportionate share issue include HCFA, AHA, CBO, and ProPAC. At this time, the results of these projects are still preliminary. No findings have been published or presented in final form. Information about the findings of these studies is anecdotal, and the results may change significantly before the analyses are finalized. This section summarizes these preliminary findings.

First, some of this research suggests that for some hospitals there is a relationship between the proportion of a hospital's care accounted for by low income patients (measured in various ways) and the hospital's Medicare cost per case. That is, there may be a "disproportionate share" effect. To the extent that this effect exists, its impact on Medicare operating cost per case is greatest for large urban hospitals (possibly large hospitals in large urban areas). There is apparently little, if any, disproportionate share effect among rural hospitals, except for rural hospitals with very high percentages

of "poor" patients. Also, there does not seem to be any significant difference in the effect between public and private large urban hospitals.

Second, there appears to be an interaction between the disproportionate share effect and both (1) the teaching adjustment factor (ratio of interns and residents to beds as used in determining PPS payment levels) and (2) location factors. That is, changes in the definition of either the teaching adjustment or the wage index (i.e., incorporation of the core/ring concept or other change) may either strengthen or weaken the apparent need for a disproportionate share adjustment, depending on the exact nature of the change.

Third, based primarily on work by the CBO, there appears to be a threshold level below which differences in the amount of care provided to low income patients have little or no effect on hospitals' Medicare cost per case. Specifically, it appears that there is no relationship between the proportion of a hospital's care provided to the poor (variously defined and measured) and Medicare cost per case for urban hospitals who provide less than 15 to 20 percent of their total care to low income patients. For hospitals above this threshold, Medicare cost per case increases as the proportion of care to low income patients increases. Additionally, the effect of an increase in the proportion of low income care on a hospital's cost per case is larger for hospitals substantially above the threshold (e.g., 40 to 50 percent low income care) than for hospitals at, or just above, the threshold. While the exact level of the threshold and percentage increases in cost per case may vary somewhat depending on which measure of care to the poor is utilized, the existence of the threshold effect appears to be consistent across measures.

Continuing research is building on these preliminary findings. Work is now being done on the evaluation of alternative measures of disproportionate share and on the detailed specification of adjustment formulae.

IV. MAJOR ISSUES IN THE DEVELOPMENT OF AN ADJUSTMENT FOR DISPROPORTIONATE SHARE HOSPITALS

The purpose of this section is to discuss the major policy issues related to the development of an adjustment to the payment rates for disproportionate share hospitals under the Medicare prospective payment system and to provide a brief discussion of the policy alternatives that are currently available to address each issue. For this purpose, the issues have been divided into four groups: the problem of defining and identifying disproportionate share hospitals, the problem of designing a specific rate adjustment given the available research findings, the problem of financing a rate adjustment, and the issue of future review and revision of current policy choices as new data and additional research findings become available.

A. Defining and Identifying Disproportionate Share Hospitals

1. The Policy Goals

As indicated in Section II above, Section 1886(d)(5)(C)(i) of the Social Security Act gives the Secretary authority to provide exceptions and adjustments to the PPS payment rates to ". . . take into account the special needs of . . . public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this title." However, the nature of the "special needs" that might warrant a rate adjustment for such hospitals is not specified in the law. In response

to this ambiguity, different views have developed regarding both the substance of the special needs referred to and the scope of the intended policy response.

The term "special needs" could be interpreted to include a broad array of specific problems found in hospitals serving low income or Medicare patients, ranging from potentially higher costs of treating patients that are more severely ill to the cost of providing uncompensated care (services provided to patients for which the hospital receives no payment). Generally, however, the term "special needs" has been interpreted more narrowly. Thus, the costs of additional services and more costly services that may be required to meet the needs of low income or Medicare patients would be included only to the extent that such costs result in higher Medicare operating costs per case in hospitals serving disproportionate numbers of such patients. Moreover, the possibility of additional payments to hospitals under Medicare for such costs as uncompensated care has been excluded, usually on the grounds that Section 1861(v) of the Social Security Act specifically prohibits Medicare from paying for the costs of services provided to persons not entitled to benefits under the program.

There has been general agreement that DSH's have "special needs" only to the extent that their Medicare costs per case are higher than in otherwise comparable hospitals. Of the two broad classes of patients named by the DSH legislation (low income and Medicare Part A), the research on this issue has consistently shown that the number of Medicare patients served has no apparent impact on Medicare cost per case. Thus, most analysts have discounted the volume of Medicare patients as a basis for a DSH payment adjustment. On the other hand, the recent research has also shown consistently that the shares of both non-Medicare low income patients and low income Medicare patients affect Medicare cost per case separately and in combination.

Within this general view of the intent of the disproportionate share provision, however, there has been debate regarding the primary focus of the policy. Some observers argue that the goal is to adjust Medicare payments to reflect the higher Medicare costs of hospitals that serve primarily poor patients including poor Medicare patients. Others argue that the goal is to adjust Medicare payments to reflect the higher Medicare costs of hospitals serving low income Medicare patients only, regardless of whether or not they serve low income patients generally.

Depending on the outcome of this debate, different hospitals would receive additional payments and the same hospitals would receive different amounts. Different measures (either low income patients or low income Medicare patients) would be used to identify disproportionate share hospitals depending on the different definitions of the policy goal. Although the hospitals that would be identified by these alternative measures would overlap to a large degree, some hospitals identified as DSHs by one measure would not be included by the other.

Even for the hospitals that meet both definitions, the distributions of the relevant measures (e.g., the percentage of all patients that have low incomes and the percentage of all patients that are low income Medicare patients) would differ across the hospitals. As a consequence, the estimated relationship between Medicare cost per case and the disproportionate share measure would be different for each measure. Thus, depending on the disproportionate share measure used, both the total amount of disproportionate share payments and the distribution of such payments across hospitals could turn out to be quite different.

2. Alternative Approaches to Measurement of Low Income and Low Income Medicare Patient Shares

The principal problem in measuring the volume and relative shares of low income and low income Medicare patients in individual hospitals is the absence of data on patient income levels. At present, hospitals do not generally inquire about or record information about the income levels of their patients. Similarly, the Health Care Financing Administration does not collect information about the income levels of persons entitled to benefits under the Medicare program. As a result, attempts to measure the volume of low income or low income Medicare patients have had to rely on one or more proxy measures that are intended to represent patient characteristics which cannot be measured directly. The proxy measures that are currently available are described below. A brief discussion of the limitations of each measure as a basis for identifying disproportionate share hospitals is also provided.

a. The volume of patients eligible for benefits under Medicaid.

The percentage of total hospital inpatient care provided to patients eligible for benefits under State Medicaid programs has been widely used to represent a hospital's share of inpatient services provided to low income patients. This measure has been defined in two ways: the share of total admissions, or the share of total inpatient days, provided to patients for whom the expected principal source of payment is the State Medicaid program. Currently, the main source of these data is information voluntarily reported to the American Hospital Association (AHA) by individual hospitals responding to the AHA's annual survey of hospitals. Although information regarding the volume of Medicaid admissions and patient days is requested on the Medicare hospital cost reporting form, often these items are not reported since they are currently unrelated to payment under Medicare.

Since patients can become eligible for Medicaid benefits only if they have low income, these measures probably do reflect the distribution of low income patients across hospitals to some extent. The degree to which a hospital's share of Medicaid patients may represent its share of low income patients, however, is limited by several important factors. First, eligibility standards (maximum income levels) for Medicaid benefits vary widely among the State Medicaid programs. For example, the maximum income level for eligibility in the most restrictive State programs represents less than 30 percent of the income level established by the Federal poverty standard, while the income eligibility threshold in the most generous programs is about twice the Federal poverty standard. Thus, the percentage of the low income population that may qualify for Medicaid benefits is highly variable across States. As a result, the volume of Medicaid patients may represent very different percentages of the volume of low income patients across the States. This suggests that hospitals in States with generous Medicaid programs would benefit more than hospitals in other States from a DSH payment adjustment based on the share of Medicaid patient days. Second, certain groups of persons (e.g., single persons and childless couples) are excluded by Federal law from eligibility for Medicaid benefits.

Third, the rates paid by State Medicaid programs to hospitals for services provided to Medicaid patients also vary substantially from one program to another, which may affect the distribution of Medicaid patient volume across hospitals within States. For example, where the payment rates are relatively low, so that Medicaid patients are financially unattractive to hospitals, Medicaid patient volume may be concentrated in a few hospitals that serve large numbers of low income patients. On the other hand, if the Medicaid payment policy is relatively generous, Medicaid patient volume may be more evenly distributed

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across hospitals. Fourth, a number of States impose limits on the number of inpatient days covered by the Medicaid program per recipient per year and a few limit the number of days per admission. These limits also may affect the degree to which Medicaid days represents a reasonable proxy measure of services provided to low income patients. Finally, since hospitals classify patients according to the principal expected source of payment, the Medicaid patient volume reported by hospitals excludes low income Medicare patients even if they are also eligible for Medicaid benefits (dual eligibles) because under these circumstances Medicare is the primary payer.

Taken together, these considerations suggest that the reported volume of Medicaid admissions or patient days provides a highly variable representation of the degree to which individual hospitals serve low income patients. Further, these proxy measures do not represent the extent to which hosptials serve low income Medicare patients.

b. Medicaid patient volume adjusted for variations in State Medicaid programs. Some attempts have been made to address the problem of State variations in Medicaid eligibility standards by adjusting the reported Medicaid patient volume data for the hospitals in each State to reflect the Medicaid volume that would exist if all States had uniform eligibility standards relative to the Federal poverty income threshold. This approach is based on the assumption that if a State's Medicaid eligibility standard represents 50 percent of the Federal poverty threshold, then Medicaid patient volume in its hospitals is only half as large as it would be if the State's eligibility standard were raised to the poverty threshold. If this assumption is approximately correct, then the Medicaid volume data reported by the hospitals in each State can be made approximately comparable if they are multiplied by the ratio of the Federal poverty income threshold to the State's eligibility standard. For example, if

the Federal poverty threshold is $10,000 and the State's eligibility standard is $4,000, the Medicaid patient volume data reported by each hospital in the State would be multiplied by 2.5 ($10,000 divided by $4,000). The resulting Medicaid admissions or patient days would be assumed to represent the volume of patient care that would be provided by each hospital to low income patients if all persons (otherwise eligible) below the poverty line were eligible for Medicaid benefits in each State.

While this approach provides a potentially effective means of adjusting Medicaid data for interstate differences in Medicaid eligibility standards, some major problems would remain. First, this approach assumes that the low income population not eligible for Medicaid receives hospital services from the same hospitals in the same relative shares as Medicaid patients do. There is very little reason, however, to suppose that this assumption is accurate, especially in particular States. For example, States in which the Medicaid payment rates are relatively attractive, or those in which the Medicaid program contracts with a limited subset of hospitals to provide all inpatient services to Medicaid patients, are not likely to have highly similar distributions of Medicaid and low income patients across hospitals. The result of the adjustment process in these cases would be similar estimates of low income patient volume for hospitals which, in fact, serve different numbers of such patients, or different estimates for hospitals that actually serve similar numbers of low income patients. Second, the adjusted proxy measures would still exclude low income Medicare patient volume. Finally, although adjusted historical Medicaid volume data may provide a somewhat better basis than unadjusted data for estimating the relationship between the volume of low income patients and Medicare operating costs per case, the use of crude State-wide adjustment factors in making adjustments to the payment rates for individual hospitals

could result in substantial errors and inequities. On the other hand, administratively feasible means of obtaining more direct measures of the volume of low income patients served by individual hospitals are not readily apparent.

c. Volume of inpatient services provided to dually-eligible Medicare patients. Substantial efforts have also been made to adjust the Medicaid low income proxy measures for the exclusion of low income Medicare patients. This problem has been addressed by adding an estimate of the volume of patient care provided to Medicare patients who are dually-eligible for Medicaid benefits for whom the State has agreed to pay the Medicare part B premium (Medicare "buy-ins" under agreements established under the provisions of Section 1843 of the Social Security Act). This proxy measure has also been suggested as a potential basis for a disproportionate share adjustment tied to the volume of patient care provided to low income Medicare patients.

Estimates for individual hospitals of the volume of Medicare buy-in patients have been developed by CBO from sample Medicare beneficiary history files for several years. These files identify Medicare beneficiaries for whom the States have purchased part B coverage under Medicare and the hospital(s) in which they received inpatient treatment during each year. The resulting estimates are intended to represent the extent to which individual hospitals provide inpatient services to low income Medicare patients.

Like the other proxy measures discussed above, this one also has limitations. First, one State does not currently participate in the buy-in program and therefore, the extent to which its hospitals serve low income Medicare patients cannot be represented. Second, the proportion of dually eligible persons for whom the States choose to buy part B coverage may vary somewhat from State to State. Third, the proportion of Medicare low income beneficiaries granted eligibility for Medicaid benefits depends on whether the State has a medically

needy program and whether the State has chosen to include medically needy Medicare beneficiaries in its buy-in agreement with the Medicare program. As a result, the volume of services provided to Medicare buy-in patients may not accurately represent the volume of services provided to low income Medicare beneficiaries.

d. Volume of inpatient services provided to low income Medicare beneficiaries. An alternative hospital-specific measure of the volume of services provided to low income Medicare beneficiaries could be developed by merging census data with information from hospital bills submitted for payment under Medicare. In this approach, census data regarding the income distribution of elderly persons residing in each zip code area would be used to estimate the proportion of elderly residents in each area with incomes below a poverty threshold. Information from Medicare bills for hospital inpatient care would be used to identify the proportion of the Medicare patients served by a hospital residing in each zip code area. Together, these data would provide a basis for estimating the proportion of the hospital's Medicare patients with incomes below the chosen poverty threshold.

This estimate would be based on the assumption that the proportions of poor and non-poor patients served from each zip code area are the same as the proportions of poor and non-poor elderly residents in each area. If, for example, a hospital's Medicare patients were equally divided between two zip code areas with 20 percent and 60 percent poor elderly residents, respectively, then the hospital's estimated share of low income Medicare patients would be 40 percent ((.5 X .2) + (.5 X .6)). Stated another way, this approach is based on the assumption that poor and non-poor elderly residents choose essentially at random among the hospitals in the general area where they live when they need inpatient care. To the extent that this assumption is violated, the measure

may provide an inaccurate representation of the volume of poor Medicare patients served by different hospitals.

Thus far, this approach has not been implemented or tested. However, HCFA has indicated that it is in the process of developing this measure for testing later this year.

e. The share of gross revenues attributable to Medicaid, bad debts and charity care. Several of the hospital associations have suggested that the proportion of a hospital's gross revenues attributable to Medicaid patients, bad debts and charity care could provide a useful measure of the extent to which the hospital serves low income patients. This measure is based on the sum of the percentages of the hospital's total charges that are charged to Medicaid patients, that are written-off as uncollectable, or that are charged to patients who are considered charity cases and are not expected to pay some portion or all of their bill. Currently, the only source for these data is the confidential responses of the subset of hospitals (about 2300 in 1981) that complete the revenue portion of the AHA's annual survey each year.

This measure also has major limitations. First, the relevant data are reported on a confidential basis by only about one-half of the hospitals subject to payment under Medicare's PPS. Second, accounting policies and debt collection practices vary widely, with hospitals writing-off unpaid charges after varying periods of time and pursuing collection of unpaid bills with various degrees of effort. Similarly, charity care policies vary substantially among hospitals. As a result, this proxy measure may not represent accurately the extent to which individual hospitals provide services to low income patients.

3. Methods for Identifying Hospitals that Serve a Disproportionate Number of Low Income or Low Income Medicare Patients

Aside from a method based on an arbitrary threshold value (e.g., any hospital in which the percentage of total patient days accounted for by Medicaid patients exceeds 25 percent), disproportionate share hospitals may be identified by two different types of methods. In the first method, disproportionate share hospitals are defined by a threshold value based on the distribution of the applicable patient volume measure across hospitals. For example, the threshold might be established as the value of the volume measure which would identify the top 20 percent of the hospitals (the 20 percent of hospitals having the highest values of the volume measure). An alternative approach within this type of method would set the threshold value by taking into account the average value of the patient volume measure and the amount of variation in the measure across hospitals. In this approach, for example, the threshold might be set at the average patient volume plus one or two times the standard deviation of the measure (an indicator of the spread of the patient volume values across the hospitals). This approach would be similar to the method currently used to establish the length of stay and cost thresholds for outlier cases under PPS.

This type of method might be appropriate in certain circumstances. If, for example, Congress decided to provide a fixed amount of funds to be distributed among disproportionate share hospitals, then the top 20 percent kind of approach might provide part of the means of allocating the available funds. Similarly, if it turned out that patient volume (e.g., low-income Medicare volume) tends to increase hospitals' Medicare costs per case only in hospitals with very high volume, then the approach based on the average value plus some number of standard deviations might be preferred. On the other hand, this type of approach yields a definition of disproportionate share hospitals that is based

on relatively little information and the choices that determine the threshold (e.g., the top 20 percent or the number of standard deviations added to the average volume level) are still relatively subjective.

The second type of method would define disproportionate share hospitals on the basis of the estimated relationship between the patient volume measure and Medicare operating cost per case, taking into account any other variables that may interact with the patient volume measure. If research suggests, for example, that hospitals with values of the patient volume measure above a particular level (e.g., low income Medicare patient days as a percentage of total patient days above 18 percent) tend to have significantly higher costs per case, then the disproportionate share threshold would be defined by that level. Similarly, if the results indicate that only urban hospitals with low income Medicare patient days representing 20 percent or more of total patient days have higher costs per case, then disproportionate share hospitals would be defined by the combination of the two variables: urban location and a low income patient share of 20 percent or more.

B. Designing a Disproportionate Share Adjustment

Once the disproportionate share hospitals have been defined and identified, the issue of how to design an appropriate payment adjustment for such hospitals must be addressed. The design of a specific rate adjustment will determine the basis of additional payments for disproportionate share hospitals, the aggregate amount of additional payments, and the distribution of additional payments among such hospitals. In addition, the design of a disproportionate share payment policy should address the issue of potential interrelationships between the adjustment for disproportionate share hospitals and other elements of the PPS payment formula such as the indirect medical education adjustment. Finally,

given the limitations of the available patient volume measures, the issue of whether or not all disproportionate share hospitals would be recognized by an automatic payment adjustment may also be important. These issues are briefly discussed below.

1. The Payment Adjustment Formula

An automatic payment adjustment formula for disproportionate share hospitals could be designed as either a flat percentage adjustment or as a variable percentage adjustment to the PPS rates otherwise payable to the hospital. In the first case, the percentage adjustment could be determined by the average percentage increase in Medicare costs per case experienced by all disproportionate share hospitals as shown by the base year data (1981) used to develop the PPS system.

As noted above, however, preliminary research findings suggest that the impact of the share of low income or low income Medicare patients on Medicare cost per case increases with the level of the patient share measure. That is, above a threshold of 15-20 percent, as the share of low income or low income Medicare patients increases, Medicare cost per case increases as well. Hypothetically, for example, a disproportionate share hospital serving 25 percent low income patients might have Medicare costs per case that are 5 percent higher than an otherwise comparable non-disproportionate share hospital. Similarly, a hospital serving 35 percent low income patients might have Medicare costs per case that are 10 percent higher than would otherwise be expected.

These preliminary findings suggest that a variable percentage adjustment to the PPS payment rates may be more appropriate than a flat adjustment. Under this approach, disproportionate share hospitals serving high proportions of low

income or low income Medicare patients would receive larger percentage adjustments to their payment rates than hospitals serving relatively low proportions of such patients.

2. Interrelationships With Other Elements of the PPS System

Preliminary research findings suggest that many hospitals that serve a disproportionate share of low income or low income Medicare patients are also large teaching hospitals. Further, it is apparent that there is some overlap between the effect of the share of low income patients (or low income Medicare patients) on Medicare cost per case and the effect of teaching activity on cost per case. This suggests that if a disproportionate share adjustment is adopted, it may be appropriate to reduce the indirect teaching adjustment factor at the same time. Similarly, other changes in PPS payment policy (e.g., a change in the wage index) may have some implications for the size of a disproportionate share adjustment.

3. Accounting for the Limitations of the Disproportionate Share Measure

As described above, the current disproportionate share measures all have fairly substantial limitations in terms of how well they represent the extent to which individual hospitals serve low income or low income Medicare patients. As a result, some hospitals that are disproportionate share hospitals may not be identified as such by a particular measure. Unless an appeals mechanism is provided, these hospitals would not qualify to receive any payment adjustment.

C. Financing a Disproportionate Share Adjustment

Once the issues regarding identification of hospitals deserving of a disproportionate share adjustment and specification of the formula for making the adjustment have been resolved, the question arises of how to finance the adjustment. One potential method for financing a disproportionate share adjustment is to increase Medicare outlays. It is not possible to estimate the cost of this approach without first defining the exact form and structure of the proposed adjustment formula. There are two alternative financing options that could be used, either alone or in combination, to limit the effect of a disproportionate share adjustment on Medicare outlays. These are: 1) financing some or all of the adjustment through offsetting changes in other aspects of the PPS pricing formula, particularly through changes in the indirect teaching adjustment; and 2) imposing a "budget neutrality" restriction on the disproportionate share adjustment.

1. Financing the Adjustment through Offsetting Changes

Some research has suggested that there is a correlation between the amount of care hospitals provide to the poor and the size of their graduate medical education programs. That is, many of the hospitals that are, by one or more criteria, disproportionate share hospitals are also hospitals that receive substantial adjustments in their PPS payment rates through the indirect teaching adjustment. It has been suggested that some portion of the cost of a disproportionate share adjustment might be offset by a concurrent reduction in the indirect teaching adjustment. The net effect of this offset would be to redirect some of Medicare's outlays for hospital care from teaching hospitals that do not provide disproportionate amounts of care to the poor to hospitals

(both with and without teaching programs) that do provide a disproportionate share of care to the poor. Preliminary estimates by the CBO suggest that, given certain assumptions about the design of the disproportionate share adjustment, as much as 60 percent of the cost of the disproportionate share adjustment could be offset through a 25 percent reduction in the indirect teaching adjustment factor.

2. Budget Neutral Financing

If it were decided that a disproportionate share adjustment would be implemented only if it did not increase Medicare outlays, there are several options to consider in the design of a budget neutral approach. First, budget neutrality could be imposed on a national basis. This proposal has the advantage of spreading the burden of the adjustment over the largest number of hospitals, assuring that hospitals not receiving the adjustment would have their payment rates adjusted downward as little as possible. However, the existing research suggests that for most definitions of disproportionate share hospitals, urban hospitals are the most likely to receive an upward adjustment. If budget neutrality were imposed on a national basis, this provision would probably shift payments from rural to urban hospitals.

An alternative to the national approach would be to impose the provision over some subset of PPS hospitals. For example, the disproportionate share adjustment could be made budget neutral across all urban hospitals, while allowing for a small increase in outlays due to adjustments for rural disproportionate share hospitals outside of the budget neutrality equation. This approach has the advantage of keeping the current relationship between payments to urban and rural hospitals relatively constant. The disadvantage of this approach is that the burden of the disproportionate share adjustment is spread

over a smaller group of hospitals. That is, urban hospitals that are not identified as disproportionate share hospitals would potentially have their payments reduced by substantial amounts. Depending on how the adjustment is defined and calculated, it is even possible that some urban hospitals could have their payment levels reduced below that of rural hospitals.

D. Future Review and Revision of a Disproportionate Stare Adjustment

Some have suggested that any disproportionate share adjustment be reviewed and perhaps revised within a few years of implementation. Because the data currently available to develop such an adjustment are limited, it may be that in the intervening period additional data could be collected to better define and identify disproportionate share hospitals. For example, as part of a disproportionate share adjustment, HCFA could be instructed to collect data on hospital patients who are dually-eligible for both MEdicare and Medicaid. These data could represent a more inclusive measure of patients who have low income than the currently available data on Medicaid eligibles for whom States "buy-in" to the Medicare program. The adjustment could provide a date by which such additional data should be collected and used in a DSH adjustment.

Also, there is considerable interaction among the variables which lead to higher hospital costs and among the features of the Prospective Payment System designed to address those costs. As ways are developed to either correct deficiencies in PPS (such as the indirect medical education adjustment), any disproportionate share adjustment developed now may need to be further analyzed and perhaps changed. Some have indicated that a DSH adjustment should have a sunset date at which time the available data could be reanalyzed to indicate whether such an adjustment were still necessary and, if so, what its design should be.

Opening Statement of Senator Robert Dole

I am looking forward to this hearing and to achieving real progress toward the development of a method to provide a payment adjustment for those hospitals who serve an unusually large proportion of the low income and elderly.

As those present at this hearing are well aware, we have discussed the need for such an adjustment for some years and had hoped by this time to have in place such an adjustment. In the Tax Equity and Fiscal Responsibility Act of 1982, the Social Security Amendments of 1983 and the Deficit Reduction Act of 1984, we directed the construction of an adjustment that would take into account the special needs of disproportionate share hospitals. Yet, we still do not have in place an acceptable mechanism to meet the need.

I am fully aware of the difficulties in devising both a measurement tool to identify hospitals whose patient mix warrant such an adjustment, and a system of adjustments that fairly recognizes these costs. Clearly none of us have an interest in returning to cost based reimbursement, which is always the risk when you begin to provide for adjustments. But, I am convinced we can find some middle ground.

Preliminary research findings seem to underscore the existence of a so-called disproportionate share effect, and I expect further work will bring forward even more information.

While the proposal being suggested by the House Ways and Means Committee and the one being put together by Senators Durenberger, Bentsen, and myself, may not provide the perfect long-term solution, we are nevertheless hopeful that it will provide a good short term first step and will serve to underscore our desire to address this issue. I fully expect that the research efforts outlined in the administration's testimony will help us devise a long-term policy.

I want to compliment Senator Durenberger for holding this hearing. I also offer my thanks to the witnesses for their willingness to share their insights with us.

Opening Statement of Senator John Heinz

Mr. Chairman: I commend you for holding this hearing today. I would hope that we on the Finance Committee might follow the lead of our colleagues on the House Ways and Means Committee and provide for a disproportionate share adjustment under the prospective payment system when we write our Medicare reconciliation bill.

Mr. Chairman, our nation's public and teaching hospitals today shoulder a heavy financial burden in providing care to millions of Americans trapped in illness without health insurance or the cash to pay hospital expenses out of pocket. The critical life-and-death role these facilities play was brought home to me at a recent hearing of the Senate Special Committee on Aging, which I have the honor to chair.

This hearing focused on the problems of the medically uninsured. Members of the Committee learned that the number of uninsured swelled by more than 20 percent between 1979 and 1983, and has now reached an estimated 35 million. Most of these Americans use hospital emergency rooms for a doctor's office. However, increasing competition in the hospital sector and changes in the reimbursement system—led by Medicare's change to prospective payment—have limited the ability of hospitals to shift the costs of their non-paying patients to other payers. As a result, fewer and fewer hospitals are willing to open their doors to people who are uninsured and have no money to pay for their care. Even the most public-spirited institutions cannot continue to carry a bottom line of millions of dollars in uncompensated services.

At this hearing, members of the Aging Committee heard from representatives of two of the nation's major public hospitals, Cook County in Chicago and Cuyahoga in Cleveland, about the consequences of being what are, in fact, last resort hospitals for our nation's poor. They described how patients are turned away from other hospitals, and all too often dumped, into Cook County and Cuyahoga's inpatient and outpatient facilities. They described how increasing numbers of indigent patients and decreasing dollars in local, state and federal revenues are squeezing the life out of these hospitals' ability to provide quality care for the indigent and uninsured.

In my home state of Pennsylvania, Temple University Hospital provides $10 million annually in uncompensated care. That is 10 percent of its operating budget. In fact, Temple is the 4th largest provider of indigent care among university hospitals in the United States. While Temple has and will continue to serve Philadelphia's poor, it needs some help.

Mr. Chairman, I believe that within Medicare's prospective payment system recognition should be given to hospitals like Cook County, Cuyahoga and Temple. I

look forward to working with you and the other members of this Committee on designing an adjustment to PPS that will recognize the special burden—the disproportionate burden—of those hospitals which treat large numbers of low-income and Medicare patients.

OPENING STATEMENT OF SENATOR GEORGE J. MITCHELL

Mr. Chairman, I want to thank you and the Subcommittee for your interest in the issue of additional Medicare reimbursement for those hospitals which serve a disproportionately large number of low income and Medicare patients.

Those of us who serve on this Subcommittee are aware of the problems faced by many hospitals adjusting to the Prospective Payment System enacted in 1982. Hospitals are not all created equal. Some facilities serve many more poor and elderly patients than average. Some facilities are in rural areas where lower utilization may increase the cost of health care.

I believe it is commendable that the Congressional Budget Office and the Prospective Payment Assessment Commission have been in the process of data collection to determine the causal relationship between higher hospital costs and larger percentages of low income and Medicare patients. I do, however, question the length of time it has taken to begin to see any data from these studies.

I am aware of the action taken in the House Subcommittee on Health recently which requires the Secretary of HHS to make additional payments under PPS to urban hospitals with 100 or more beds serving a disproportionately large share of low income and Medicare patients. I am very concerned, however, about the fate of rural hospitals who serve a similar population.

In my home State of Maine, there are a number of small rural hospitals who are already having difficulty surviving under the Prospective Payment System. Some of these facilities have well over 50% of their patients who are on Medicare and Medicaid or have no health insurance at all.

I am very interested to hear the testimony from Dr. Davis as well as the testimony to be presented by the witnesses from CBO and the Prospective Payment Assessment Commission. I look forward to learning more about their data collection process and what their findings indicate about the need to additionally reimburse both urban and rural hospitals which serve a large percentage of the poor and elderly.

Senator DURENBERGER. The hearing will come to order.

Everyone elese here knows that the chairman of the subcommittee was on time today and the Administrator of HCFA was not. But I said if anyone is entitled to be late on her last appearance before this committee, it is Carolyne Davis. And I'm going to say a few of the many nice things I could say about her at the end of my prepared remarks.

Since September 3, 1982, legislation to reform Medicare's methods for paying hospitals has contained a provision for the special treatment of hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of Medicare. Although the Secretary of Health and Human Services has promulgated regulations, flaunting congressional policy by freezing hospital reimbursement rates, medical education reimbursement, reducing the reimbursement formula for home health agencies and a variety of other budgetary regulations, she took until July 1, 1985 to publish interim rules on disproportionate share hospitals, and then only because a Federal court 11 months earlier ordered her to do so.

And she took the full 11 months. And, further, she appealed a district court order, and last week it was stayed by Justice Renquist. So today we may hear that the administration will stand behind Judge Renquist rather than the Congress.

Carolyne, I promise I will not shoot the messenger.

Now we will hear again today what we have been hearing for nigh onto 3 years. We will hear that the 1982 law, the 1983 law and the 1984 law on disproportionate share hospitals is ambiguous as to its mandate; that the best-intentioned enforcers have difficulty finding adequate data with which to identify disproportionate share hospitals, and that even if we found them we would have difficulty determining the nature of the payment.

Well, the Ways and Means Committee has already answered all three of those questions. And it's just possible that the Senate Finance Committee will do the same. Our answers, however, even when conferenced this fall, may be less than accurate or adequate. But that's because the administration has wasted the better part of 3 years in formulating the answers they are much better staffed to research and decide. And once again, budget policy will make legislative policy more difficult and your legislator will take the heat for a job less than well done.

This hearing is designed to help us do the best we can with the information and the resources available. And that is just what this Senator intends to do. We will legislate an answer to this problem this year. It may come in the form of amendments to the indirect teaching reimbursement formula, an area I have been working on for some time. Or it may come in an adjustment to the deadline for compliance with a nationally averaged prospective payment system for qualifying disproportionate share hospitals, an idea which occurred to me just this past weekend. Or both.

For the benefit of those of you who are here today to help us with this task, permit me to outline a few principles to keep our disproportionate share initiative consistent with past Medicare policy and with the Medicare reform policies which have guided us all since the Social Security Act of 1983.

First, disproportionate share legislation will not be designed to bail out hospitals. Get that, Jack?

The purpose of the Medicare prospective payment reform and health systems reform in general is to provide incentives for cost-effective management of hospitals and to reward the efficient. That is why the Congress moved away from a hospital-specific, cost-based payment system to one based on prospectively set per case prices. The old cost-based system was inflationary and promoted inefficient management of hospital services. Public hospitals and others which primarily treat the poor did well in the cost-based environment because they passed their higher costs, bad debts, and inefficiencies on to third party payers.

In a pricing system for Medicare, many of them are in trouble. Their survival per se is not Medicare's concern. It is only important that Medicare's pricing system not inhibit access to care or its beneficiaries.

Second, unless and until the law is changed and we decide to tax the payroll of working people in America to pay for indigent care, Medicare is not intended to subsidize our access of the nonelderly poor to hospital care in America. Medicare cannot be in the business of saving public or intercity hospitals at the expense of all other hospitals, at the expense of the elderly or the disabled or at the expense of the work of Americans.

The Congress has mandated commitment for Medicare's resources to finance its share of medical education. And we will make a recommitment to medical education in this year's legislative package. But we do this because it is directly relevant to the quality health care of the elderly and disabled who are entitled to Medicare.

I have been careful to articulate the limits of our commitments to the poor via the Medicare trust fund. But this does not mean that the Congress can leave to Cosby, Stills, and Nash, who are holding concerts to raise money for the poor in this country, the financing of the health care of 30 million disadvantaged Americans.

I have said many times how impressed I was to learn that the greatest killer of children in America today, 10,000 young victims last year alone, is poverty. And that is unconscionable. And it is also unconscionable that this administration would have us cut more deeply into the national response to this crying need, and that this Congress would be so ineffectual in its commitment to health care for indigent Americans as it has been.

Third, the Finance Committee and the U.S. Senate, since the problem of the disproportionate share hospitals came on the congressional scene in 1982, has always seen this as an issue, in large part, of severity of illness. The Secretary hasn't been able to find a severity index to help make the prospective payment system more realistic. And even if she had, we would probably still be considering the disproportionate share issue because, as we will learn today, there are factors of the sick poor beyond simple severity of illness, which add to the cost of their treatment treatment. Nutritional deficiency, chemical dependence, lack of family, social service requirements and locational costs are examples.

So we will be looking for severity measures but not ignoring those others.

And, finally, this Senator in particular will make two additional arguments. One is of location and the other of federalism. While most people, the Ways and Means Committee included, seem to think of disproportionate share in terms of downtown Chicago or Parklawn in Dallas. It's no accident that the Secretary was sued by a 40-bed hospital in Red Bud, CA.

I think the problem is in many ways worse in rural America where choices are so limited and population is both older and poorer. I'm just afraid our big-city researchers are going to overlook the Red Buds and the Windoms, MN, in their sampling.

And this leads me to federalism. For 4 years now, we have been practicing devolution of responsibility from the Federal to State and local governments without devolution of resources. The administration would have us make a bad situation worse by eliminating deductibility of State and local taxes, eliminating tax-exempt bond financing, and increasing the Federal role in excise taxes, a field except in wartime usually left to the States.

The problem in Red Bud and in Windom is a poor tax base, which throughout rural America is getting poorer every everyday. The municipalities and the counties cannot pay to provide access for their indigent citizens to hospitals or to maintain those public hospitals. And to make the problem even worse, the States are all

cutting their taxes and their spending on income maintenance in an effort to attract the Saturn plans of this crazy world. Even before that competition for industry, the disparity in State commitment to indigents, which we have blessed with Federal reimbursement, which varies from $138 a month AFDC payments in Tennessee, the new home of Saturn, to $474 a month in New York City, to $533 a month in Wisconsin and $524 a month in Minnesota.

Those are the principles.

I want now to thank our witnesses for taking the time from busy schedules to come appear before this subcommittee today. And I would particularly like to commend the Congressional Budget Office for the splendid work it has done on the disproportionate share issue. CBO has done a yoeman's job on a terribly compex issue and has done it in a very short period of time.

Our first witness today will be Dr. Carolyne Davis, the Administrator of the Health Care Financing Administration. This is the last time that Carolyne will be appearing before this subcommittee, at least in her capacity as Administrator of HCFA. So I would like to express my appreciation for the job that she has done. I have gained personally from the years that I have worked with her, and obviously wish her the best in her future career. I've noticed that Carolyne has literally criss-crossed this country during her tenure at HCFA, making herself available and learning by listening. She is committed to health systems' reform, and the Nation should never forget and probably will never forget that it was on her watch that the fundamental changes in America's health-care system were launched. Reform has been successful because of her commitment and her willingness to weather the storms of budget cutting, the obstinacy of OMB and much more, including the introductory statement I just made.

Disproportionate share may be one of those issues where the obstacles are there despite Carolyne Davis' efforts. Let's find out.

Carolyne.

STATEMENT OF DR. CAROLYNE K. DAVIS, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC, ACCOMPANIED BY ALLEN DOBSON, DIRECTOR, OFFICE OF RESEARCH, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC

Dr. DAVIS. Thank you, Mr. Chairman.

I appreciate the opportunity to appear today and to discuss our efforts, to look at the issue of the hospitals that serve a disproportionate share of low-income and Medicare patients. As I listened to your opening statement, I noted your concern and your frustration. I want to assure you that I, too, am frustrated at the inability to find a clean solution to this problem. I do like to finish a job once it is started and I leave knowing this one is not a finished product at this point in time.

Over the last several years we've been doing our best to try and define the issue and determine where and whether there is, indeed, a problem regarding the Medicare reimbursement component. And,

finally, then try to develop a policy approach that would be based on solid data and analysis that would lead to an equitable outcome.

I think the issue is probably clearer than it was 2 or 3 years ago. The research, however, hasn't provided a clear policy approach. Each one of the different options that we've looked at, and that you will hear about today, seem to have serious drawbacks. More importantly they produce different conclusions with respect to who is a disproportionate share hospital and what, if anything, is the problem. As a result, we are not in a position to implement an equitable solution at this specific time.

I think the disproportionate share issue arises from a variety of concerns, some of which are related to Medicare and others of which are simply a function of increased competition in the health care sector. For some the issue is a subset of a broader issue, in which uncompensated care in general. But I believe, as you do, that the Medicare statute requires us to define the question a—the precise manner does a hospital that treats a significant disproportionate share of low-income patients, have higher than average Medicare costs per case? Because if it does then it's clear that there is an issue that we need to address because that would mean that it is not receiving its fair share of reimbursement under the prospective payment system. But if it doesn't have higher costs, then it appears to us that the financial problem wouldn't be due to inadequate reimbursement from Medicare, but rather a shortfall in the revenues for the services that are provided to the non-Medicare patients. Later this year, we do have a report due to Congress looking at the whole issue of uncompensated care.

Although we are concerned about the uncompensated care issue, it seems that we would be precluded by the Medicare statute from modifying our reimbursement policy to subsidize hospital care provided to non-Medicare patients. Even beyond that statutory restriction, it's important for us to remember, given the status of the trust funds, that it would not be an appropriate use of the restricted trust fund money.

In both TEFRA and the Social Security Amendments of 1983, the Secretary was given authority to grant exceptions and adjustments, taking into account the special needs of the public and other hospitals that serve a disproportionate number of patients who have low income and are entitled to benefits under part A. Therefore, initially we focused on the public general hospitals. Even though previous analysis didn't indicate any special adjustments were warranted, during the spring of 1983 we took another look and the outlines of study in this area were agreed upon with representatives from the public hospitals. That study focused on the large hospitals located in urban areas in order to determine if the public hospitals in that group would incur higher Medicare costs per case after we adjusted for the case mix index, and the wage index, the bed size, and the ratio of interns and residents to beds. This study didn't find any difference in Medicare-allowable inpatient operating expenses or the discharges between public general hospitals and other hospitals that were of similar size and location.

In the Deficit Reduction Act of 1984, Congress mandated that we develop a list of disproportionate share hospitals. Since the bill dropped the reference to public hospitals our search shifted away

from focusing on public hospitals, as a group, to looking at disproportionate share as a bigger issue across all hospitals. The major issue that we then faced in the research was to try and determine a proxy for the number of low-income patients treated in a hospital because there is no national data base to directly link income levels to hospital utilization and cost data at individual hospital levels.

Various research approaches have been used to date, and we have come up with approximately four different proxies for low-income patients. They were developed primarily by our research staff talking with the Propac staff, and CBO staff, and others. The proxies include Medicaid admissions. Medicaid admissions adjusted for differences in coverage of the poverty population; the aged Medicaid admissions and the American Hospital Association's so-called misery index.

Our research has examined the use of both Medicaid admissions and adjusted Medicaid admissions as a proxy for low-income patients. We hope to look at the latter two, the aged Medicaid admissions, and the AHA's misery index in the near future.

If you use either the Medicaid or the adjusted Medicaid admissions as a proxy, we did find that there was an effect on the average Medicare cost per case. For example, with the Medicaid admissions as the proxy. We found that across all hospitals for every 10-percent increase in Medicaid admissions there was two-tenths of 1 percent increase in Medicare costs per case.

However, when the hospitals were then divided into urban and rural settings, different results were observed. For urban hospitals, we found that the effect was double that found in the national data. And in the rural areas, there was no longer a statistically significant effect.

But when using the national data, an adjustment would require a shift of something like $300 million among the hospitals. And if you use just the urban-rural data, it would be $538 million that would be shifted among the urban hospitals.

Given that we have received correspondence on the disproportionate share issue as a concern of both urban and rural hospitals, I found the lack of significant results for rural hospitals very puzzling. For me, it reinforces the question of the adequacy of the currently available proxies. For if the proxy is adequate, I think we would have seen some effect on the rural hospitals, but we didn't.

Any adjustment would be a shift among the hospitals rather than an increase in the total reimbursement because it is, indeed, refinement within the perspective payment system. And when you think about the fact that the basic assumption is that a hospitals operate on the average, and the current payments assume that the hospitals serve an average percent of the low-income individuals, then to the extent that a hospital serves a significantly disproportionate share of the low income and this causes higher Medicare costs, it would be deemed underpaid relative to the hospitals that have less than the average low-income caseload.

Any additional payment that compensates those hospitals should come from a reduction in the overpayments to the hospitals with less than the average low-income admissions. But although we did find a disproportionate share effect, using the Medicaid admissions

as a proxy for the low-income patients, there are significant problems, I believe, with that proxy, and with the data used to get that proxy.

By using the Medicaid admissions as a proxy for low-income patients, one would assume that the relationship between these variables is the same across all the States. And that's clearly not true because of the differences in the scope of the State Medicaid programs. There is quite a substantial variation in Medicaid eligibles as a percent of the low-income individuals; it ranges from 143 percent in Massachusetts to about 25 percent in Texas. If the disproportionate share adjustment is meant to correct the impact of treating individuals below the poverty line, then the payment based on a percent of Medicaid would provide more of an adjustment than warranted to hospitals in the States such as Massachusetts, while probably providing less than warranted in a State such as Texas.

In response to that problem, the Prospective Payment Commission developed a proxy which adjusted Medicaid admissions for differences in the coverage of the poverty population and we have examined this proxy in our research efforts.

Using that particular adjustment, the hospital in Texas with, say, 10 percent Medicaid admissions would be treated as if it had 26 percent low-income admission, while a hospital in Massachusetts with the same 10-percent Medicaid admissions would be treated as if it had 4.5 percent low-income admissions. We believe that that kind of an adjustment is too dramatic. So even though the PROPAC adjustment has some very intuitive appeal, the end result, to us, appears to be to some extent arbitrary. The adjustment increases the percent Medicaid factor for a hospital in a limited Medicaid State on the assumption that the hospital is treating a nationally representative share of low-income patients given the level of poverty in a specific area—that may or may not be true for a particular hospital.

A second concern with a Medicaid proxy is that it does not include individuals over the age of 65. Medicare eligibles are not counted under the Medicaid Program but under Medicare, since Medicare is their primary payer. As a result, the most direct link between treating the poor patients in Medicare—in other words, treating the Medicare patients who are also poor—isn't available in that analysis. And since the ratio of these cross-over individuals, then any listing of the disproportionate share hospitals would be inaccurate too.

Another problem with using Medicaid admissions as a proxy for the percent of low-income patients is the data source. The AHA data base is a decided improvement over the Office for Civil Rights data, but, again, it has some significant drawbacks. Data are missing or incomplete for approximately 18 percent of the hospitals or about 1,000 of them. Further, the data have not been used previously. Also, they are voluntarily reported and not audited, and, therefore, we have some degree of question about their reliability.

In fiscal year 1984 cost reports, we intend to obtain audited data on the percent of Medicaid admissions. But that's not available yet, and it's not going to allow for an equitable disproportionate share adjustment prior to fiscal year 1987.

In addition to the percent of Medicaid admissions or adjusted Medicaid admissions two other proxies are being used for low-income patients.

The Congressional Budget Office [CBO] has attempted to develop a percent of Medicaid aged proxy using statistical techniques to estimate that variable for each State. The American Hospital Association [AHA] has used a fourth proxy in its analysis of the disproportionate share issue. AHA has created a misery index based on the percent of the hospitals' revenues that are Medicaid, bad debt, or charity care.

Both of these proxies also have some serious deficiencies. In order to come up with a more reliable adjustment factor, we are undertaking a major research initiative to look at the poverty population by ZIP Code using the census data. Using that data, we hope to be able to construct a unique percent low-income admissions for each hospital. However, that analysis won't be completed in time for next year's regulation. We expect to have it completed by June 1986.

In conclusion, I would simply state that we have made major progress, I believe, in defining the issue of disproportionate share, but we are not in a position at this point in time to feel that we have an equitable adjustment for disproportionate share.

I think, too, our position is supported by the fact that each of the alternatives explored to date generate significantly different results and we are very puzzled as to what that means. Indeed, our most recent research efforts produced a result even more sobering than these differences among the disproportionate share list. Within the past month, we have taken another look at our study results using the adjusted Medicaid proxy. Previously, we compared the impact of the various intervals of—percent Medicaid to the effect of close to no percent Medicaid. Since the PPS rates are based on averages, it may be more appropriate to take the average percent Medicaid as the norm. When we did that, significant results vanished and there was no longer a disproportionate share effect.

The results of all of these various analyses, have given us reason to pause before we take approximately half a billion dollars and redistribute it between hospitals. It seems fairer to continue our current method of payment than to make an adjustment that ends up being arbitrary in terms of its definition of the disproportionate share hospital.

I want to assure you that we are committed to developing an equitable response to the disproportionate share issue. We plan to continue our research efforts to ascertain the most appropriate proxy for low-income patients. We will report the results back to your committee within 1 year. Thank you.

Senator DURENBERGER. Thank you very much.

[The prepared written statement of Dr. Davis follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Washington, D.C. 20201

STATEMENT OF
CAROLYNE K. DAVIS, PH.D.
ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON HEALTH
FINANCE COMMITTEE

UNITED STATES SENATE

JULY 29, 1985

I AM PLEASED TO BE HERE TODAY TO DISCUSS OUR EFFORTS TO DATE TO ADDRESS THE ISSUE OF HOSPITALS WHICH SERVE A DISPROPORTIONATE SHARE OF LOW INCOME AND MEDICARE PATIENTS.

OVER THE PAST FEW YEARS, WE HAVE BEEN DOING OUR BEST TO DEFINE THE ISSUE, TO DETERMINE WHETHER THERE IS INDEED A PROBLEM REGARDING MEDICARE REIMBURSEMENT AND, FINALLY, TO DEVELOP A POLICY APPROACH WHICH IS BOTH BASED ON SOLID DATA AND ANALYSIS AND WOULD LEAD TO EQUITABLE RESULTS.

ALTHOUGH THE ISSUE IS MORE CLEARLY DEFINED THAN IT WAS THREE YEARS AGO, RESEARCH TO DATE HAS NOT PROVIDED A CLEAR POLICY APPROACH. EACH OF THE CURRENTLY AVAILABLE OPTIONS NOT ONLY HAS SERIOUS DRAWBACKS, BUT ALSO PRODUCES DIFFERENT CONCLUSIONS WITH RESPECT TO DISPROPORTIONATE SHARE HOSPITALS. AS A RESULT, WE ARE NOT IN A POSITION TO IMPLEMENT AN EQUITABLE SOLUTION AT THIS TIME.

DEFINING THE ISSUE

THE DISPROPORTIONATE SHARE ISSUE ARISES FROM A VARIETY OF CONCERNS, SOME DIRECTLY RELATED TO MEDICARE AND OTHERS WHICH ARE FUNCTIONS OF THE INCREASING COMPETITION IN THE HEALTH CARE SECTOR. FOR SOME, THE ISSUE OF DISPROPORTIONATE SHARE IS A SUBSET OF THE BROADER QUESTION OF UNCOMPENSATED CARE. WE BELIEVE THAT THE STATUTE REQUIRES US TO DEFINE THE QUESTION IN A MORE PRECISE MANNER.

Our perspective, and I believe the perspective of the members of this committee, is that the issue is whether hospitals which treat a significantly disproportionate share of low income patients have higher average Medicare costs per case. If they do, then it is an issue that the Medicare program needs to address because they are not receiving their fair share of reimbursement under the prospective payment system.

If they don't, any financial problems are not due to inadequate Medicare reimbursement but are the result of a short-fall in revenues for services provided to non-Medicare patients. Although we would be concerned about the issue, we are precluded by statute from modifying our reimbursement policies to subsidize hospital care provided to non-Medicare patients. Beyond the statutory restriction, we do not believe that such a policy would be an appropriate use of Trust Fund monies.

DISPROPORTIONATE SHARE AND MEDICARE

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 gave the Secretary authority to grant exemptions from, and exceptions and adjustments to the Section 223 total cost limits to take into account "the special needs of psychiatric hospitals and of public or other hospitals that serve a significantly disproportionate number of patients

WHO HAVE LOW INCOME OR ARE ENTITLED TO BENEFITS UNDER PART A OF THIS TITLE."

THEN, AS TODAY, THERE WAS NO KNOWN DATA ON THE INCOMES OF PATIENTS SERVED BY HOSPITALS. CONGRESSIONAL CONCERN CENTERED PRIMARILY ON PUBLIC GENERAL HOSPITALS; HOWEVER, OUR PREVIOUS ANALYSIS HAD SHOWN THAT NO SPECIAL ADJUSTMENT WAS WARRANTED FOR THESE HOSPITALS. THUS, WHEN THE TEFRA REGS WERE PUBLISHED ON SEPTEMBER 30, 1982 WE INDICATED THAT "WE HAVE NOT YET DEVELOPED ANY PROVISIONS OF THIS TYPE."

THAT DECEMBER, IN OUR REPORT TO CONGRESS ON A HOSPITAL PROSPECTIVE PAYMENT SYSTEM (PPS) WE STATED THAT "PRELIMINARY EVIDENCE FROM THE MEDICARE STATISTICAL SYSTEM ... INDICATES THAT ONCE CASE MIX AND OTHER FACTORS THOUGHT TO AFFECT COSTS WERE TAKEN INTO ACCOUNT, URBAN PUBLIC HOSPITALS ARE NO MORE EXPENSIVE THAN OTHER HOSPITALS."

THE SOCIAL SECURITY AMENDMENTS OF 1983, WHICH ENACTED PPS, AGAIN GAVE THE SECRETARY AUTHORITY TO PROVIDE EXCEPTIONS AND ADJUSTMENTS TO TAKE INTO ACCOUNT THE SPECIAL NEEDS OF "PUBLIC OR OTHER HOSPITALS THAT SERVE A SIGNIFICANTLY DISPROPORTIONATE NUMBER OF PATIENTS WHO HAVE LOW INCOME OR ARE ENTITLED TO BENEFITS UNDER PART A."

IN RESPONSE TO THIS LEGISLATION, DURING THE SPRING OF 1983

WE TOOK ANOTHER LOOK AT THE PUBLIC HOSPITAL ISSUE. THE OUTLINES OF OUR STUDY WERE AGREED UPON WITH REPRESENTATIVES FROM THE PUBLIC HOSPITALS. IT FOCUSED ON LARGE HOSPITALS LOCATED IN URBAN AREAS TO DETERMINE IF PUBLIC HOSPITALS IN THIS GROUP INCURRED HIGHER MEDICARE COSTS PER CASE AFTER ADJUSTING FOR CASE MIX INDEX, MEDICARE WAGE INDEX, BED SIZE AND THE RATIO OF INTERNS AND RESIDENTS TO BEDS.

THE STUDY DID NOT FIND ANY DIFFERENCE IN MEDICARE ALLOWABLE INPATIENT OPERATING EXPENSES PER DISCHARGE BETWEEN PUBLIC GENERAL HOSPITALS AND OTHER HOSPITALS OF SIMILAR SIZE AND LOCATION. WHEN THE PPS REGS WERE PUBLISHED ON SEPTEMBER 1, 1983 WE INDICATED THAT WE "HAVE NOT FOUND A SIGNIFICANT ASSOCIATION BETWEEN HIGHER MEDICARE COSTS PER CASE AND EITHER PUBLIC OWNERSHIP OR THE PROPORTION OF LOW INCOME PATIENTS."

IN THE DEFICIT REDUCTION ACT OF 1984 (DEFRA), CONGRESS MANDATED THAT THE SECRETARY DEVELOP A LIST OF DISPROPORTIONATE SHARE HOSPITALS. THE STATUTORY LANGUAGE, HOWEVER, DROPPED THE REFERENCE TO PUBLIC HOSPITALS. OUR RESEARCH EFFORTS THEREFORE SHIFTED AWAY FROM TRYING TO EXAMINE PUBLIC HOSPITALS AS A GROUP TO LOOKING AT DISPROPORTIONATE SHARE AS AN ISSUE ACROSS HOSPITALS.

THE MAJOR ISSUE WE FACED IN OUR RESEARCH WAS DETERMINING A

PROXY FOR THE NUMBER OF LOW INCOME PATIENTS TREATED IN A HOSPITAL. THERE IS NO NATIONAL DATA WHICH DIRECTLY LINKS INCOME LEVELS TO HOSPITAL UTILIZATION AND COST DATA AT THE INDIVIDUAL HOSPITAL LEVEL. THE VARIOUS RESEARCH EFFORTS TO DATE HAVE COME UP WITH FOUR PROXIES FOR LOW INCOME PATIENTS. THEY ARE: MEDICAID ADMISSIONS, MEDICAID ADMISSIONS ADJUSTED FOR DIFFERENCES IN COVERAGE OF THE POVERTY POPULATION, AGED MEDICAID ADMISSIONS AND THE AMERICAN HOSPITAL ASSOCIATION'S (AHA) SO-CALLED "MISERY" INDEX.

OUR RESEARCH, TO DATE, HAS EXAMINED THE USE OF BOTH MEDICAID ADMISSIONS AND ADJUSTED MEDICAID ADMISSIONS AS A PROXY FOR LOW INCOME PATIENTS. WE ARE ALSO IN THE PROCESS OF OBTAINING INFORMATION WHICH WOULD ALLOW US TO EXAMINE THE USE OF AGED MEDICAID ADMISSIONS. WE HAVE ATTEMPTED TO OBTAIN THE DATA USED BY THE AMERICAN HOSPITAL ASSOCIATION (AHA) TO CONSTRUCT THE "MISERY" INDEX, BUT WE HAVE BEEN UNABLE TO DO SO BECAUSE OF CONFIDENTIALITY ISSUES WITH THE DATA.

USING EITHER MEDICAID OR ADJUSTED MEDICAID ADMISSIONS AS THE PROXY, WE FOUND AN EFFECT ON AVERAGE MEDICARE COSTS PER CASE. FOR EXAMPLE, WITH MEDICAID ADMISSIONS AS THE PROXY WE FOUND THAT, ACROSS ALL HOSPITALS, FOR EVERY 10 PERCENT INCREASE IN MEDICAID ADMISSIONS THERE WAS A TWO TENTHS OF ONE PERCENT INCREASE IN MEDICARE COSTS PER CASE. HOWEVER, WHEN HOSPITALS WERE PARTITIONED INTO URBAN AND RURAL

SETTINGS DIFFERENT RESULTS WERE OBTAINED. FOR URBAN HOSPITALS, WE FOUND THAT THE EFFECT WAS DOUBLE THAT FOUND IN THE NATIONAL DATA, WHILE IN RURAL AREAS THERE WAS NO LONGER A STATISTICALLY SIGNIFICANT EFFECT.

BECAUSE THE PERCENT OF MEDICAID ADMISSIONS VARIES ACROSS HOSPITALS FROM 0 TO 90 PERCENT, WE HAD TO DETERMINE THE MAGNITUDE OF THE MEDICARE EFFECT AT INCREASING LEVELS OF MEDICAID ADMISSIONS. WE EXAMINED THE MEDICARE EFFECT FOR EACH CHANGE OF THREE PERCENTAGE POINTS IN PERCENT MEDICAID UP TO 30 PERCENT. BASED ON THE RESULTS OF NATIONAL DATA, WE THEN COMBINED HOSPITALS INTO THREE GROUPS.

STARTING WITH THE 5,400 HOSPITALS UNDER PPS, WE HAD TO ELIMINATE 1,000 FROM OUR STUDY DUE TO DATA PROBLEMS. OF THE REMAINING 4,400 HOSPITALS, WE FOUND 3,880 HOSPITALS WITH 0 - 18 % MEDICAID, 374 HOSPITALS WITH 18 - 30 PERCENT AND 144 WITH MORE THAN 30 PERCENT. THE IMPACT OF PERCENT MEDICAID WAS NOT SIGNIFICANT FOR THE FIRST GROUP, IT WAS HOWEVER FOR THE LATTER TWO GROUPS. FOR EVERY 10 PERCENT INCREASE IN MEDICAID ADMISSIONS THERE WAS A SIX TENTHS OF ONE PERCENT INCREASE IN MEDICARE COSTS PER CASE FOR THE 18 - 30 PERCENT GROUP AND 1.3 PERCENT FOR THE MORE THAN 30 PERCENT GROUP. IF PAYMENTS WERE TO BE ADJUSTED BASED ON THESE RESULTS, A TOTAL OF $294 MILLION WOULD HAVE TO BE SHIFTED AMONG HOSPITALS. IF JUST THE URBAN DATA IS USED, A TOTAL OF $538

MILLION DOLLARS WOULD BE SHIFTED AMONG URBAN HOSPITALS.

THE ADJUSTMENT WOULD BE A SHIFT AMONG HOSPITALS RATHER THAN AN INCREASE IN TOTAL REIMBURSEMENT BECAUSE IT IS A REFINEMENT OF THE PPS SYSTEM. THE BASIC ASSUMPTION OF PPS IS THAT HOSPITALS OPERATE AT THE MEAN. THUS, CURRENT PAYMENTS ASSUME THAT HOSPITALS SERVE AN AVERAGE PERCENTAGE OF LOW INCOME INDIVIDUALS. TO THE EXTENT THAT A HOSPITAL SERVES A SIGNIFICANTLY DISPROPOTIONATE SHARE OF LOW INCOME PATIENTS, AND THIS CAUSES HIGHER MEDICARE COSTS PER CASE, IT IS BEING UNDERPAID RELATIVE TO THE HOSPITALS THAT HAVE A LESS THAN AVERAGE LOW INCOME PATIENT LOAD. ANY ADDITIONAL PAYMENT TO COMPENSATE THOSE HOSPITALS WITH A SIGNIFICANTLY DISPROPORTIONATE SHARE OF LOW INCOME ADMISSIONS SHOULD COME FROM A REDUCTION IN THE OVERPAYMENT TO HOSPITALS WITH LESS THAN AVERAGE LOW INCOME ADMISSIONS.

PROBLEMS WITH DISPROPORTIONATE SHARE "SOLUTION"

ALTHOUGH WE DID FIND A DISPROPORTIONATE SHARE EFFECT USING MEDICAID ADMISSIONS AS A PROXY FOR LOW INCOME PATIENTS THERE ARE SIGNIFICANT PROBLEMS BOTH WITH THE PROXY AND THE DATA USED TO GET THE PROXY.

- BY USING MEDICAID ADMISSIONS AS A PROXY FOR LOW INCOME PATIENTS, ONE ASSUMES THAT THE RELATIONSHIP BETWEEN THESE TWO VARIABLES IS THE SAME ACROSS

STATES, WHEN THIS IS CLEARLY NOT TRUE. STATES MUST PROVIDE COVERAGE TO AFDC AND MOST SSI CASH RECIPIENTS. THE PERCENT OF POOR INDIVIDUALS COVERED BY THESE PROGRAMS, HOWEVER, VARY FROM STATE TO STATE. IN ADDITION, WHILE SOME STATES PROVIDE COVERAGE TO INDIVIDUALS WHO ARE NOT RECEIVING CASH BENEFITS, THE SO-CALLED MEDICALLY NEEDY, OTHER STATES DO NOT.

BECAUSE OF THESE DIFFERENCES IN THE SCOPE OF STATE MEDICAID PROGRAMS, THERE IS SUBSTANTIAL VARIATION IN MEDICAID ELIGIBLES AS A PERCENT OF LOW INCOME INDIVIDUALS, RANGING FROM 143 PERCENT IN MASSACHUSETTS TO 25 PERCENT IN TEXAS.

IF THE DISPROPORTIONATE SHARE ADJUSTMENT IS MEANT TO CORRECT FOR THE IMPACT OF TREATING INDIVIDUALS BELOW THE POVERTY LINE, PAYMENT BASED ON PERCENT MEDICAID WOULD PROVIDE MORE OF AN ADJUSTMENT THAN WARRANTED TO HOSPITALS IN STATES LIKE MASSACHUSETTS WHILE PROVIDING LESS THAN WARRANTED IN TEXAS.

In response to this problem, Prospective Payment Assessment Commission (PROPAC) staff developed a proxy which adjusted Medicaid admissions for differences in the coverage of the poverty population. This is one of the proxies that we examined in our research efforts.

Using the PROPAC adjustment, a hospital in Texas with 10 percent Medicaid admissions would be treated as if it had 26 percent low income admissions, while a hospital in Massachusetts with the same 10 percent Medicaid admissions would be treated as if it had 4.5 percent low income admissions. We believe that this adjustment is too dramatic.

Although the PROPAC adjustment has some intuitive appeal, the end result to some extent is arbitrary. The adjustment increases the percent Medicaid factor for a hospital in a limited Medicaid state on the assumption that overall the hosspital is treating a nationally representative share of low income patients given the level of poverty in its area. This may or may not be true for a particular hospital.

A SECOND CONCERN WITH THE PERCENT MEDICAID IS THAT IT DOES NOT INCLUDE INDIVIDUALS OVER 65. MEDICARE ELIGIBLES ARE NOT COUNTED UNDER MEDICAID BUT UNDER MEDICARE, SINCE IT IS THEIR PRIMARY PAYOR. AS A RESULT, THE MOST DIRECT LINK BETWEEN TREATING POOR PATIENTS AND MEDICARE, THAT IS, TREATING MEDICARE PATIENTS WHO ARE ALSO POOR, IS NOT AVAILABLE FOR ANALYSIS. SINCE THE RATIO OF THESE "CROSS OVER" INDIVIDUALS TO TOTAL MEDICAID PATIENTS VARIES ACROSS HOSPITALS, ANY LISTING OF DISPROPORTIONATE SHARE HOSPITALS BASED ON PERCENT MEDICAID WILL BE INACCURATE.

ANOTHER PROBLEM WITH PERCENT MEDICAID AS A PROXY FOR PERCENT LOW INCOME IS THE DATA SOURCE. ALTHOUGH THE AHA DATA BASE IS AN IMPROVEMENT OVER THE OFFICE OF CIVIL RIGHTS SURVEY DATA THAT WE USED IN OUR EARLIER ANALYSIS, IT DOES HAVE SIGNIFICANT DRAWBACKS.

- FIRST, DATA ON MEDICAID UTILIZATION ARE MISSING OR INCOMPLETE FOR 1,000 OR 18 PERCENT OF ALL HOSPITALS.

- SECOND, THE DATA HAVE NOT BEEN USED PREVIOUSLY. THEY ARE VOLUNTARILY REPORTED AND NOT AUDITED.

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THEREFORE THEIR RELIABILITY IS QUESTIONABLE.

In the FY 1984 cost reports, HCFA will obtain audited data on the percent of Medicaid admissions. However, because it is not yet available, it will not allow for an equitable disproportionate share adjustment prior to FY 1987.

In addition to Medicaid and adjusted Medicaid, two other proxies are being used for low income patients. The Congressional Budget Office (CBO) has attempted to develop a percent Medicaid aged using statistical techniques to estimate this variable for each State. There are considerable reliability problems with the data used in this analysis.

In order to come up with a more reliable adjustment factor, HCFA is undertaking a major research initiative which will look at the poverty population by zip code using census data. With this data we hope to be able to construct a unique percent low-income admissions for each hospital. This analysis will be completed by June 1986.

The AHA has used a fourth proxy in its analysis of the disproportionate share issue. It has created a "misery" index based on the percent of a hospital's revenues that are

MEDICAID, BAD DEBT OR CHARITY CARE. ALTHOUGH THIS APPROACH WOULD SEEM TO ADDRESS SOME OF THE PROBLEMS IN THE USE OF PERCENT MEDICAID CREATED BY THE VARIATIONS IN STATE MEDICAID PROGRAMS, THERE ARE SERIOUS PROBLEMS WITH THE AVAILABLE DATA ON BAD DEBT.

- MANY HOSPITALS REPORT VOLUME DISCOUNTS GIVEN TO LARGE PURCHASERS, SUCH AS BLUE CROSS, AS BAD DEBT;
- BAD DEBT OCCURS WHEN A BILL IS NOT PAID, REGARDLESS OF WHETHER OR NOT THE PATIENT COULD AFFORD TO PAY AND IT VARIES AS A FUNCTION OF COLLECTION EFFORTS;
- CHARITY CARE MIGHT INCLUDE FREE CARE GIVEN TO COURTESY PATIENTS, SUCH AS HOSPIATL EMPLOYEES; AND
- AS WITH OTHER AHA DATA, THIS INFORMATION IS PROVIDED VOLUNTARILY AND IS UNAUDITED. FROM THEIR MOST RECENT DATA, ONLY 2500 HOSPITALS REPORTED BAD DEBT AND CHARITY CARE DATA.

CONCLUSION

WE HAVE MADE MAJOR PROGRESS IN DEFINING THE ISSUE OF DISPROPORTIONATE SHARE. HOWEVER, I BELIEVE THAT WE ARE NOT IN THE POSITION, AT THIS TIME, TO MAKE AN EQUITABLE

ADJUSTMENT FOR DISPROPORTIONATE SHARE. OUR POSITION IS SUPPORTED BY THE FACT THAT EACH ALTERNATIVE EXPLORED TO DATE GENERATES SIGNIFICANTLY DIFFERENT RESULTS.

OUR MOST RECENT RESEARCH EFFORTS PRODUCED A RESULT THAT IS EVEN MORE SOBERING THAN THESE DIFFERENCES AMONG THE DISPROPORTIONATE SHARE LISTS. WITHIN THE PAST MONTH WE TOOK ANOTHER LOOK AT OUR STUDY RESULTS USING THE ADJUSTED MEDICAID PROXY. PREVIOUSLY, WE COMPARED THE IMPACT OF VARIOUS INTERVALS OF PERCENT MEDICAID TO THE EFFECT OF CLOSE TO NO PERCENT MEDICAID. SINCE PPS RATES ARE BASED ON AVERAGES, IT MAY BE MORE APPROPRIATE TO TAKE THE AVERAGE PERCENT MEDICAID AS THE NORM. WHEN WE DID JUST THAT, THE SIGNIFICANT RESULTS VANISHED AND THERE NO LONGER WAS A DISPROPORTIONATE SHARE EFFECT. SURELY, THIS TYPE OF RESULT MUST GIVE ONE PAUSE BEFORE HALF A BILLION DOLLARS IS TRANSFERRED BETWEEN HOSPITALS.

WE BELIEVE THAT IT IS FAIRER TO CONTINUE THE CURRENT METHOD OF PPS PAYMENT, WITH ITS ASSUMPTION THAT ALL HOSPITALS SERVE AN AVERAGE PROPORTION OF LOW INCOME PATIENTS, THAN TO MAKE AN ADJUSTMENT THAT REDISTRIBUTES HUNDREDS OF MILLIONS OF DOLLARS BASED ON AN ARBITRARY DEFINITION OF A DISPROPORTIONATE SHARE HOSPITAL.

WE ARE FIRMLY COMMITTED TO DEVELOPING AN EQUITABLE RESPONSE

TO THE DISPROPORTIONATE SHARE ISSUE. WE PLAN TO CONTINUE OUR RESEARCH EFFORTS IN ORDER TO ASCERTAIN THE MOST APPROPRIATE PROXY FOR LOW INCOME PATIENTS. WE WILL REPORT ON OUR RESULTS TO THIS COMMITTEE WITHIN ONE YEAR.

THANK YOU FOR PROVIDING ME WITH THE OPPORTUNITY TO REPORT ON OUR EFFORTS TO DATE. I WOULD BE HAPPY TO ANSWER ANY QUESTIONS THAT YOU MAY HAVE.

Senator DURENBERGER. Max, do you want to do an opener or just questions?

Senator BAUCUS. Question, but no statement.

Senator DURENBERGER. All right.

I laid out a couple of principles in my opening comments, and I didn't see much disagreement among us. Let me make sure of that. First, that Medicare is not in the same business that Hill Burton was in, in effect; nor the reverse of that. We are not here to save hospitals with a payroll tax in this country that is now about $5,400, $5,500 per worker per year going up to $8,000 over the next few years.

Also, that we are concerned about the transition from a system we lived with in this country for a whale of a long time; that is, a cost-based reimbursement system that gave us a lot of hospitals and gave hospitals a lot of problems, to another system in which we are, in effect, prospectively pricing the services that we intend to buy.

And do you disagree with the need to transist on at least an institutional basis to provide some kind of a transition from where we were to where we ought to be. And the only issue between us—the only issue that exists out there really is how long that transition is going to have to take. Is that fairly accurately stated?

Dr. DAVIS. I think that's fairly accurately stated.

Senator DURENBERGER. When I got to the last of these guiding principles—and I think you reiterated part of this, too—that at least from this committee's standpoint we have traditionally come at disproportionate share at least in some substantial part by looking at severity of illness. And I elaborated on the components of severity as it applies to the lederly poor, and talked about social service requirements, and talked about the nonexistence of families and nutritional deficiencies and chemical dependency which all contribute to disproportionate share. From your own experience, is there any reason to believe that that isn't an accurate characterization of a concern that we share that Medicare ought to have, as we explore this period of transition?

Dr. DAVIS. Well, I think it's very clear that we don't know all of the reasons behind why there are these vast differences. As I tried to indicate, every time that we do an analytical search, we are not

able to come up with the same results. It would be a lot more comforting to us if we could find any two of these kinds of variables that would mesh together. It would then tell us perhaps some leading indicators as to the problems behind the differences. We recognize the whole severity of illness index is one that we are working on. We have a report due to Congress, as you know. We are funding about six different severity studies right now and several of them hold quite a bit of promise.

Senator DURENBERGER. So our main problem is deciding at this stage, if we are going to implement something today and we only have *x* number of dollars to do the implementation—our problem is who gets it and who gets how much. Is that about where we are at?

Dr. DAVIS. That's right. And I think our concern is that when we start rearranging dollars, that we want to make certain that we take them away from those who don't need them and give them to those who do. Since our lists come out differently with each set of research that we do on the disproportionate issue, we are reluctant to start rearranging what can be some fairly significant dollars per case, depending upon what the results of the research show.

Senator DURENBERGER. Where did the figure of one-half billion dollars that you used in your testimony come from as the price of doing disproportionate share?

Dr. DAVIS. I will ask Dr. Dobson if he will explain that.

Dr. DOBSON. We took percent of Medicaid admissions and we used that as a proxy in our modeling. We then came up with the adjustments within categories. No adjustment up to 15 percent, a 11-percent adjustment between 15 and roughly 30 percent, and then above 30 percent another adjustment. We modeled that across the Nation's hospitals in our data base, of which there were 4,400. Then we expanded it to include all the hospitals under prospective payment and their operating costs as of fiscal year 1984.

Using those kinds of simulations, we came up with a number of about half a billion dollars for urban hospitals using sort of the basic estimating relationships that we have all found.

Senator DURENBERGER. All right.

Carolyne, as I understand it, about three-fourths or maybe a little more than three-fourths of the States now have prospective payment systems for their Medicaid programs.

Dr. DAVIS. Right.

Senator DURENBERGER. Do you know what kind of adjustments they make in regard to hospitals serving disproportionate shares of low-income persons?

Dr. DAVIS. Well, the statute in OBRA did indicate that the hospital payments needed to be adjusted for that, so many of them do. I would have to get you the material. My recollection is, I think, about 15 States make an explicit adjustment for the disproportionate share. Other States have reported that they have some hospitals that don't serve a disproportionate share, and some States do it by use of the severity of illness index. Some of them use a case mix adjustment. There are a variety of mechanisms. We can do some further data analysis and submit it to the record for you.

[The information from Dr. Davis follows:]

MEDICAID STATE PLANS

Fifteen States currently have a provision in the State plan regarding hospitals that serve a disproportionate number of low income patients with special needs. A brief summary of these provisions follows:

Alabama: If the Medicaid population is one standard deviation above State mean, the operating cost upper limit is adjusted on a sliding scale.

California: Rates are adjusted for hospitals with Medicaid revenue in excess of 31 percent of total gross revenue.

Georgia: Hospitals with a high volume of low income patients with special needs receive first priority on rate appeals.

Iowa: Hospitals with 51 percent or more of total allowable costs attributable to Medicaid would receive additional reimbursement.

Kentucky: Hospitals with Medicaid population in excess of 20 percent receive 120 percent of median as rate.

Michigan: Operating cost limit for hospitals with over 25 percent Medicaid patients receive increased rate on sliding scale basis.

Minnesota: Rates are increased on a sliding scale when Medicaid admissions exceed 15 percent.

Mississippi: If a hospital has an operating cost per diem greater than maximum for class and 125 percent of statewide average Medicaid utilization occupancy level is at least equal to minimum for the hospital's class then prospective rate adjusted.

Missouri: Hospitals are allowed to appeal the rate if it has 20 percent Medicaid utilization, 60 percent patient days for government sponsored programs, Medicaid reimbursement in excess of $1 million and it can demonstrate financial distress.

Nevada: Rate adjusted if over 50 percent of patient population are eligible for Medicaid and they have neither personal nor third party resources to pay for services.

Oklahoma: Hospitals with Medicaid days in excess of 25 percent of total inpatient days are exempt from 60th percentile limit and receive base period cost plus an inflation allowance.

Oregon: Psychiatric hospitals receiving less than 20 percent of revenues from insurance payments (excluding Medicare) receive full cost.

Tennessee: Qualifying hospitals receive additional 1 percent for each 1 percent increment in utilization ratio above 8 percent or 1 percent for each increment of 1,000 inpatient Medicaid days over 3,000 days, whichever larger, but not to exceed 10 percent.

Virginia: Hospitals with over 8 percent Medicaid population have operating ceilings adjusted.

Wisconsin: A negotiated rate is allowed for hospitals with a high Medicaid volume.

Senator DURENBERGER. Do either of you happen to know why the States that don't use some kind of an index for disproportionate share don't use it?

Dr. DAVIS. There are a few States, I think they are primarily some very rural States who feel they don't have any population center that has a disproportionate share, and so they are fairly equitably distributed. I would imagine.

Senator DURENBERGER. Have they made judgments, then, about rural versus urban? You just said something about no concentration of population. Have the States been making judgments that lead us to believe that most rural hospitals do not have a problem?

Dr. DAVIS. I don't believe so. I think it's only in a selected State. I believe the State might be a State like Wyoming, which really doesn't have a very large population base in general. Certainly, its population is fairly evenly scattered, therefore, it would report that it doesn't have a problem in terms of hospitals that serve a disproportionate share.

But on the whole, I think the majority of, about 15 States that we know about, make a very explicit adjustment inside their system. But it's important to remember, too, that their systems are not all like the DRG system that we have. I mean while they are

different than the approaches of the past, they have not all moved to embrace the prospective payment system using the DRG method either.

Senator DURENBERGER. Max.

Senator BAUCUS. Thank you, Mr. Chairman.

Dr. Davis, I want to thank you for all the work that you have done in a very difficult area. This is your last appearance before this committee, I understand, and you have been working in an area that is thankless. I can think of no administrator position in this town which is as difficult as yours at a time when we are trying to reduce budget deficits. And the burden that that implies for your office is very great. And I want to thank you for the hard work that you have undertaken to try to cope with that. I think you have done very, very well, and I wish you well in whatever you do.

Dr. DAVIS. Thank you. I would just like to say that the staff in the Health Care Financing Administration are superbly capable, and if I've had any degree of success, it's because of their efforts.

Senator BAUCUS. I have a couple of questions that revolve around rural hospitals. I noted in your statement you said that there is insignificant data to indicate the dergree to which rural hospitals have a disproportionate share of low-income patients. Why were you puzzled at that sketchy data, or why were you puzzled with your apparent conclusion that the data did not show that some rural hospitals also have a disproportionate share.

Dr. DAVIS. We have heard from some hospitals in the rural areas anecdotally, at least, who tell us that they believe there is a problem from their perception. They feel that their costs are higher. Therefore, when we merged that data, and then pulled it apart, we did expect that we were going to find more relationships there than we did.

And I think I will ask Dr. Dobson, who is more familiar with the data, to elaborate.

Dr. DOBSON. What we did was we took the Nation's hospitals and we divided them into two categories—urban and rural. We then asked the question after you——

Senator BAUCUS. Rural being less than 100 beds?

Dr. DOBSON. Oh, no. Outside of an SMSA, I believe. Not distinguished by bed category.

Senator BAUCUS. All right.

Dr. DOBSON. And then we asked the question of our modeling, did the disproportionate share variable percent Medicaid make any difference after adjusting for the things that we pay for under prospective payment. And bed size, I would add.

And the answer was, and very firmly, no, it did not in rural hospitals, and, yes, it did in urban hospitals. And another indication of that was when we pulled the data back together and put national ans urban data together, the overall estimate was approximately half for the disproportionate share variable. It went from a .04 to a .02, suggesting that the rural hospitals, because there are so many som many of them, pulled down the overall estimates.

So looking at it from two different perspectives, we came to the same conclusion. That the variable we used—and that may be part of the problem, percent of Medicaid admissions may be part of the

problem here—while we didn't find it in rural areas, it was a statistically significant variable in the other analysis we did. I believe that's been confirmed by others that have done these analyses as well.

Senator BAUCUS. As I understand it, Dr. Davis, you say you are puzzled because you feel that the problem should also exist in some rural hospitals. I mean is it a problem with the ananlysis?

Dr. DAVIS. Well, I believe that every time we do do an analysis it breaks out differently, which is why we are not feeling secure enough to advance any one specific recommendation at this point in time.

Senator BAUCUS. My obvious concern is that of HCFA goes along the lines that to some degree it seems to be going; namely, to allocate disproportionate share for urban hospitals within a SMSA and I suppose hospitals more than 100 beds, and if the operating principle is budget neutrality, obviously, it's going to come out of the hide of rural hospitals. And I just strongly encourage HCFA to go back and look again at the analysis because I can tell you from experience that some rural hospitals also have this same problem.

Dr. DAVIS. Senator, that proposal which you attributed to us is not ours.

Senator BAUCUS. I understand that it is not yours.

Dr. DAVIS. We have some problems with it because, again, I think our assumption is, since we are dealing with national data, that it should be handled as a national problem; not simply as a problem of one specific group of hospitals only.

Senator BAUCUS. So you don't agree with the Ways and Means Committee's approach?

Dr. DAVIS. I would have some problems with that approach. I think we like several features about their bill and there is a sunset to it, and that——[Laughter.]

We feel it allows us at least time to straighten the whole situation out. We think within the next year we will have a viable proposal. But I have some grave concerns about why only the payments within the urban setting would increase.

Senator BAUCUS. I encourage you to go back and look at that again. When we deal with it more concretely, we will have better information.

Thank you very much.

Senator DURENBERGER. Senator Heinz.

Senator HEINZ. Yes, Mr. Chairman. Thank you very much.

I'm sorry I missed the statements of all concerned, including Dr. Davis'.

The Senate Aging Committee recently held a hearing on the problems of the medically uninsured, Mr. Chairman. And we discovered from that hearing a number of very interesting and surprising things. Of course, first—this wasn't so surprising—was that the number of medically uninsured people had increased dramatically over the last 4 or 5 years, starting in 1979, and in 1984, had reached an estimated 35 million people. And, of course, most of those people use hospital emergency rooms as a doctor's office. Some of the reasons why this has occured include increasing competition and changes in reimbursement system for Medicare, PPS. What we also found in that hearing was that there are fewer and

fewer hospitals willing to open their doors to the medically uninsured. And in a number of instances, we found hospitals that would open their doors for a little while to the medically uninsured, and then ship them on down the turnpike. This situation was described by representatives of two hospitals that testified. One, Cook County Hospital in Chicago; the other was the Cuyahoga County Hospital in Cleveland. They documented how people are literally being dumped in increasing numbers on their doorsteps. We didn't have as a witness Temple University, but Temple provides roughly 10 million dollars' worth of unreimbursed care per year, which is 10 percent of its entire operating budget. According to one survey of teaching hospitals, Temple is the fourth largest provider of indigent care among university hospitals in the United States. And now here we are in 1985; we mandated in 1982 in TEFRA a study of unreimbursed care. And I understand Dr. Davis' lack of satisfaction with the available methodologics to identify hospitals with a disproportionate share of uncompensated care, but I would like to ask you this, Dr. Davis: When we went into the prospective payment system back in 1983, we knew that there were going to be a lot of rough edges. And we knew this might be one of them. But we went ahead and said, well, we will just take our best rough cut at it. We know we are going to be arbitrary necessarily because we don't have all the information. If we had waited for all the information, we would never have done the prospective payment system. And here we are.

And now there is substantial evidence—I would say a preponderance of evidence—including evidence from PROPAC indicating that in this area of uncompensated care we really didn't do it right.

My understanding of your position is that we should wait for further studies before we do anything. I really don't understand that position, given that what we did in 1983 was necessarily arbitrary. What is being suggested that we do now is much less arbitrary that what we did in 1983. Why shouldn't we do what either PROPAC has recommended or what the House has recommended?

Dr. DAVIS. Well, in our analysis of those various proposals, we still feel that there is yet a lot to be explained. Why is it that in one analysis, you get a list of about 350 hospitals, and another one you can get a list of a thousand. It seems like that is a very wide range.

I think that our feeling is that since the data does not yet sort itself out to allow us to identify correctly what the dimensions are, that it would be capricious to start moving that much money from some hospital to another. And then perhaps have to recorrect again next year.

Senator HEINZ. But when you say "move money from one to the other"—now I understand there is a concept here called revenue neutrality. But do you maintain that what we did in the 1983 act is, in fact, revenue neutral? Hasn't it saved a great deal of money? Isn't it saving more money than was planned?

Dr. DAVIS. Not to my knowledge. Our actuaries have tried to predict as well as they could, and I believe that our initial calculations in relationship to budget neutrality were fairly accurate. Now last year we did feel that we had overestimated on the market basket, and we are trying to correct for that this year.

Senator HEINZ. All I would like to suggest is that PPS has been a great moneysaver. It has outperformed, based on the information I've gotten, any of the projections we had in 1983, even if you adjust for inflation and other macroeconomic indicators. It, therefore, seems specious to me to argue that we should be tied to a concept of budget neutrality. And maybe what we should be trying to do is recognize that in squeezing the system as hard as we did starting back in 1983, that rough edges we knew theoretically were there have, indeed, come to light and it's time, at least in this one area, to loosen up somewhat. Then a year from now, if our calibration is off, we can always tighten up. It wouldn't be the first time we've done that.

Dr. DAVIS. I would have some concerns about that, Senator Heinz, because I think the statements that you might be thinking of—and I'm not certain where you got them from—might be your reflection on the fact that we have, indeed, delayed the insolvency of the trust fund—that is true. It's due in part to the prospective payment system, but it's also due to the fact that we had a reduction in overall Medicare admissions into the system itself; not unlike what has been going on in terms of general hospital admissions. Those two factors, clearly, have delayed the insolvency. I don't think that necessarily signals that we have, in effect, saved more than we had anticipated. There are some who believe that we haven't saved enough, and I'm simply referring to our friends at the other end of the avenue.

But clearly, there has been some concern that we used unaudited data and, therefore, we ought to clean that up and adjust for that, also. So I think I would rather see us, if we are going to try to resolve this, resolve it in a budget-neutral fashion.

Senator HEINZ. On last question, if my chairman will permit me.

Senator DURENBERGER. If you want to stick on this line of questioning, keep going. I'd like to get her back here after August 9. [Laughter.]

Senator HEINZ. Have you got any sure-fire way of figuring out how to do that short of a ball and chain? [Laughter.]

A number of thoughts come to mind. If HHS and HCFA is so interested in saving money, why is it that everytime some of us propose to save money with a mandatory second opinion for selected procedures, which has just——

Senator DURENBERGER. It's been doubling again, John.

Senator HEINZ. What's that?

Senator DURENBERGER. Go ahead.

Senator HEINZ. How's that again, David? [Laughter.]

Which CBO has just estimated as saving close to a quarter of a billion dollars over 3 years; which the AARP, who speaks for senior citizens, has endorsed, which the National Council of Senior Citizens, which speaks for senior citizens, has endorsed, which the inspector general of the Department of Health and Human Services, which you are working for currently, has endorsed, and which even doctors say is a good idea even if the AMA hasn't outright endorsed it. And here we are talking about hospitals that are losing money and are having increasingly more of the 35 million medically uninsured Americans dumped by other hospitals on their doorsteps. And we are saying, well, you know, we just don't have the

money to provide for a disproportionate share adjustment. That is sheer hogwash.

Dr. DAVIS. Senator Heinz, I don't recall that we indicated our reasons for not supporting a mandatory second opinion was that we didn't have the money. I believe our lack of support was due to the fact that we think that the data—at least I know the data that the inspector general used—was from Medicaid, which does have a separate set of activities to it. It relates to including children and other factors different from the Medicare Program.

Second, is the fact that the Medicaid Program doesn't use the strict peer review system that we now do for medicare patients. In our peer review organizations, each one of them are mandated to do preadmission review on at least five——

Senator HEINZ. Tell me about the job, the one that Pennsylvania is doing right now.

Dr. DAVIS. Well, as you know, the Pennsylvania one didn't do a good job at all, and after we went to court, won the ability to take it out of service and we support a new one.

Senator HEINZ. I know this is wandering far afield, but I want to pursue some questions about the PRO's. I am a supporter of the PRO concept. Senator Durenberger, of course, worked very, very hard to make sure that we did have quality assurance. And I remember him having a set of hearings as we were headed into those 1983 amendments to ensure that we had a quality assurance programs. And I think PRO's are a fine idea. But, first, they are retrospective; and, secondly, their mandate is severely limited by their contracts, which were all bid or tightly negotiated contracts. Everybody I've talked to who is reasonably objective and is well enough positioned, I think, to know what is going on says, look, it's all very good to rely on the PRO's, apart from the fact that they deal with things after the fact. The other reality is that they do not have the capacity and are not performing exactly as they were intended because in order to get the contracts, they had to cut down their bid. Otherwise, they would all go broke.

So they are not giving the kind of service that was originally intended because we may have squeezed them. Isn't that correct?

Dr. DAVIS. Senator, I would respectively disagree with you on that point. I would like the opportunity to offer you a private briefing on what the PRO's are doing and how aggressively we are monitoring them because I think that will prove something.

Senator HEINZ. Yes.

Dr. DAVIS. There are a number of the peer review organizations that have elected on their own to conduct preadmission review. There are several States that come to mind that are doing that on their own, which means that they clearly are in a mode of being very responsive to your concerns.

Second, even those they are not, all of them must review at least 5 of the major 10 reasons for admission. They may select their five within that, but those are all done under a preadmission review so we think there is a fair amount of screening going on. We are monitoring them. The peer review organization must send us a monthly report, they are site visited by the regional offices and now they are going to have a super-PRO reviewing their activities. I'm rather proud of what they are able to do.

Senator HEINZ. You know, I don't want to get into a big discussion of the PRO's, but I will tell you what bothers me overall is that there seems to be a line of reasoning here that says: look, everything we are doing is fine and perfect and nothing should be changed, whether it's on this subject, or on disproportionate share, or whether it's on PRO's. Or, whether it's on inappropriate discharge. I mean the Department's answer seems to be that everything we are doing is fine and don't bother Congress with the details.

Now I hadn't meant to bring this up, but I'm going to. We have been going back and forth with you on obtaining information on the subject of inappropriate discharges and readmissions under PPS. And we keep being told—you have told me personally—that there are no problems. And now we find that there are some 3,700, as of March of this year, documented instances (with only half of the PROs reporting) of patients who have been discharged inappropriately. Many of these cases indicate that either the doctor was cow-towing to the hospital administrator or being incompetent. Even a layman wouldn't discharge some of these people that are being discharged and then have to be readmitted.

I don't know if you have looked at any of the 3,700 cases.

Dr. DAVIS. Yes, sir, we have.

Senator HEINZ. But you do not discharge people whose vital signs are unstable. No doctor does that. And yet we have instances after instance of that happening in spite of the assurances that you have given to the contrary. And this information has been around for a long time.

We were lucky. We didn't get it from you. We got it from someone else. We got it from a fiscal intermediary. And I don't want to debate that point; luckily, I guess for all concerned. But the point is why do we maintain the attitude that everything is fine even though we know it isn't.

Dr. DAVIS. Well, Senator Heinz, I don't believe that we have ever testified that everything is fine and that we don't want to make any changes. In fact, speaking of the peer review organizations, I testified before Senator Durenberger and the rest of you in a PRO hearing and we made some suggestions for changes in that area. Likewise, we are making a lot of changes this year as we move forward with our new regulation.

We found a problem with the area wage index. We are trying to fix that.

So I think we believe that we are trying to be responsive. In relationship to your concerns for the 3,700, the data that we have is based on that from our request to the peer review organizations to identify and send to our regional offices information anytime a transfer appears, on the surface, to be inappropriate. That means they are simply going through the first level of review. When they start reviewing them, about three-quarters of them fall out because they find that some patients went home appropriately because they were scheduled to come back later for surgery. So I think a lot of it is due to those kinds of things.

I do not believe that at any point in time we have denied your staff access to getting this data. In fact, I believe we hosted one of your staff members for several months coming in to review our

records. They are open. What we probably need is to have somebody working with them in order to clarify some of the points when they are found and clarify that we are very happy to keep our records open on those points.

We have taken aggressive action. I think it has been noted over and over—certainly in staff meetings I have indicated to the senior staff that if there is even a suspicion of a problem they should move to have the PRO's aggressively investigate further. And, in fact, we have some of our hospitals and physicians who are under what we call intensified review, meaning that all of their records are being looked at because there has been a case which has made us think they need further review. And on occasions, we have actually moved to sanctioned individuals.

Senator HEINZ. Just one question. Should we tell Cook County Hospital, Cuyahoga County Hospital and Temple University Hospital just to forget it for another year? We are not going to do anything. You have spent $10 million on uncompensated care. Just go out and raise another $4 or $5 million.

Dr. DAVIS. Senator Heinz, I know that it's difficult to not be tempted to make policy out of specific individual instances, but I think my fears would be that we may not be correcting the right thing and we might find ourselves with other unintended problems. Again, I think it is a tough judgment call. If you hear from other people this morning, you will hear they have various possible solutions. Hopefully, when you have heard them all, you will understand that because there are four, five, or six potential ways of looking at the problem, that we have not been able to crystalize around one that would make us feel like we were being less than somewhat capricious in our resolution of this.

Senator HEINZ. I want to thank the chairman for indulging me in my far-reaching questions. Mr. Chairman, I thank you and I wish you good luck in solving the problem.

Senator DURENBERGER. Thank you very much.

I was going to explore one of the answers that came back a couple of minutes ago. I think one of the problems—and maybe this is advice to your successor—is that if you are going to continue to take the position that we can't prove financial success of this program, and then come back and tell us that we are doing all of this, and that and the other thing, and we can't do this and we can't do that, you leave me with the feeling that the whole thing we are going through is some kind of a weird experiment. And I don't want to get into the subject because one way or another you know the financial success of this program. Maybe you can't measure it in the Medicare budget, but you can measure it in a thousand other ways in terms of the savings that are accruing. I mean when's the last time health insurance premiums, ay least in the last 12 months, went up. A lot of them are going down.

Dr. DAVIS. That's true.

Senator DURENBERGER. So there are other ways to measure financial success. The risk, obviously, is in taking too much credit for this success by way of budget-cutting. When out of 7,000 hospitals in the country, we are talking about 3,700 so-called early discharges. I don't know whether they are there or not. But I'll bet you if you went back before PPS there were probably more than

3,700 that you could document in one way or another. You could do the same thing with the claims that some of these competitive medical plans are ripping off people and not getting them to the right specialist and so forth. You can always find some statistics, but nobody ever compares it way ot was before.

Dr. DAVIS. That's true.

Senator DURENBERGER. When there were thousands of unnecessary surgeries. I mean women have had, you know, a variety of operations they never should have had. there was all kinds of crap going on in this country before the system started to change.

I wanted to ask you about perfecting the dual eligible status. Because it seems to me if we are going to make some progress on disproportionate share, we are going to have to look at people who are elderly-disabled in one category, but also poor. And I've been given to understand that your current Medicare data files can indentify only about 80 percent of the persons who are enrolled both Medicare and Medicaid. For example, they don't show anybody in Oregon. Nobody in Louisiana.

Dr. DAVIS. Yes.

Senator DURENBERGER. It's also my understanding that it would be possible to remedy that problem by combining the data from the Medicare and Medicaid statistical systems, a process which would give us a more concise measure of the poor elderly. Have you considered pursuing that line of research? And how long might it take you to obtain some results?

Dr. DAVIS. Yes; we have considered it. As you indicated, we only have about 80 percent of the data because the reporting is voluntary. And we use the Medicaid report on the busy-in claims. Some of the States don't have a buy-in program, therefore, they wouldn't be reporting it. For the other, since it is voluntary, sometimes they don't always report the Social Security numbers so we have some problems with getting a totally clean data base, short of requiring all the States to report this. If we were to take a look at it, and we are intending to, it is going to take us probably the better part of a year to do that. It's going to take us, I would guess, probably 5 or 10 staff people looking at during that period of time. It's a very labor-intensive activity. But we will commit ourselves towards moving in that direction.

Senator DURENBERGER. Is that a worthwhile effort?

Dr. DAVIS. It's one of those efforts that you are never sure about until you get there whether it is going to be worth it or not. I mean one of the frustrations with dealing with this whole set of issues is you think you are on track with a particular data base—just like we initially based a lot of our early work on disproportionate share on the Office of civil rights information—only to find that was so dreadfully flawed that nobody would want to see us using it.

Senator DURENBERGER. Let me ask you a question about cost shifting, transferring costs. If we get to the point where we can pin down the higher per case cost of Medicare in low-income persons and disproportionate share hospitals, are we also going to be able to establish whether all or part of that effect was or was not simply hospitals shifting cost from one compensated care, bad debts or something like that, over to Medicare because it pays. How are we going to know that?

Dr. DAVIS. Well, I'm not certain that we will have any better data base to do that in the future. However, with our new 1984 data, which is clearly from within the prospective payment system, since we set a fair rate, there is less ability for them to shift costs into the system than what might be presupposed. So if there is any squeezing down, I don't believe that there would be much ability. There wouldn't be any percentage in it in terms of trying to shift onto Medicare because we already have our rates structured.

Senator DURENBERGER. This is the last question. Have you been able to learn anything about what Max said earlier—that whatever we do in DSH will have to come out of the hides of the rural hospitals? There is other testimony here today that states the obvious. That within SMSA's there are a lot of people doing very, very well particularly in the suburban hospitals. I mean they are making out like you-know-what.

But, we thought there was only 3 years that you could put up with that sort of thing through a transition to national rates. Now it might be 4. Who knows.

Dr. DAVIS. Yes.

Senator DURENBERGER. Do you have any data available about certain hospitals within SMSA's that might help us take it out of somebody's else's hide, if we have to, without going across the board to the core city and the rural hospitals to pick up our money?

Dr. DAVIS. You mean, let's say, if you were only going to do it as an adjustment on the urbans, take it from all urbans and give it back to certain urbans?

Senator DURENBERGER. Yes.

Dr. DAVIS. That would be one way to do it.

Senator DURENBERGER. I guess what I think of is that you think in terms of the core cities and then you think of all others.

Dr. DAVIS. Dr. Dobson may have something.

Dr. DOBSON. We ran the data just for the urban hospitals and we asked ourselves what would happen if you were so-called budget neutral within urban hospitals alone. It looks to us like what you would end up doing would be surtaxing each hospital that didn't get a disproportionate share adjustment by about 1.5 percent per case or about $80 a case. So if one is willing to make the hypotheses that you have just made, and to follow along with that, technically it's feasible to have a system that moves from one urban hospital to another. We have the data and we could do that should somebody desire to do that. It would end up about $80 a case or about a percent and a half per case on those that didn't get an adjustment for a disproportionate share.

Senator DURENBERGER. Well, I thank you very much for your testimony. And there are probably some other questions that ought to be asked for the record because we are, as I indicated in the opening statement, we are going to act whether we get advice not to act or not.

Dr. DAVIS. The staff that we have that are knowledgeable about this would be happy to work with your staff as you struggle.

Senator DURENBERGER. All right. We will need that very much. And your full statement will be made a part of the record, and we thank you again very much.

Dr. DAVIS. Thank you.

Senator DURENBERGER. All right. Our next witness is Nancy M. Gordon, the Assistant Director of the Human Resources and Community Development, the Congressional Budget Office.

Nancy, thank you, as I have thanked you before, for your help in the past. And the staff that you have put together at CBO to deal with health issues, and your contribution to this issue. Your full statement will be made part of the record, and you may proceed to summarize it. If you stay within the 10 minutes the light will permit you, fine. If you don't make it, we don't penalize anybody, as you just found out.

STATEMENT OF MS. NANCY M. GORDON, ASSISTANT DIRECTOR, HUMAN RESOURCES AND COMMUNITY DEVELOPMENT, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC

Ms. GORDON. Thank you very much, Mr. Chairman.

I would like to start by introducing Stephen Long, who is seated to my right, and who is Deputy Assistant Director for Health and Income Security at the Congressional Budget Office [CBO]; and Stephen Sheingold, who is seated to my left, and who is the analyst specializing in hospital reimbursement issues.

My testimony today addresses two main issues. First, the effect of serving a large proportion of low-income patients on a hospital's costs for treating Medicare beneficiaries. And second, the options for modifying Medicare's PPS rates to reflect these costs.

I would like to start my testimony in the middle of page 4.

The two potential sources of higher hospital cost—greater severity of illness among low-income Medicare beneficiaries, and special operating and overhead costs connected with serving all low-income patients—give rise to two corresponding conceptual measures of a hospital's share of low-income patients:

The proportion of a hospital's Medicare patient load that is low income; and

The proportion of a hospital's total patient load that is low income.

Unfortunately, direct information on patients' income is not available from either hospital records or Medicare claims and enrollment files. Therefore, the income levels of a hospital's patients must be measured indirectly.

One indirect indicator of low income among Medicare patients is whether or not the Medicare Supplementary Medical Insurance [SMI] premium is directly paid for a beneficiary by a State Medicaid Program. Medicaid "buy-in" status, as it is called, is available from the Medicare enrollment files and could be used without delay. It is important to note, though, that it would not be strictly comparable across States because of difference in the income-eligibility requirements for Medicaid.

If, instead, the Congress wishes to adjust for costs attributable to all low-income patients, then some measure of non-Medicare low-income patients must also be used. One possibility is the number of non-Medicare patients for whom Medicaid is the primary payer. This measure is being collected as part of the 1984 Medicare Cost Report from each hospital. While it is also imperfect, again because

of varying income-eligibility requirements among the States, no currently available alternative appears to be better.

The CBO estimates that both measures of the proportion of a hospital's patients who have low incomes are associated with significantly higher costs for treating Medicare beneficiaries. There appear to be two thresholds at which the cost impacts manifest themselves, as shown in figure 1. The first threshold is at an extremely high concentration—55 percent and above. There is a modest increase in costs at the first threshold, less than 5 percent using the Medicare-only measure, and between 2 percent and 12 percent using the combined Medicare-Medicaid measure. But a substantially larger effect—up to 20 percent and more—occurs at the second threshold. Most of the cost impact occurs in urban hospitals with 100 beds or more. The CBO's analyses show little or no increase in costs for small urban hospitals or for urban hospitals.

Because it is possible to be certain that the relationship between concentrations of low-income patients and higher hospital costs is solely caused by the factors discussed above, these estimates should be used with caution. Particular care should be exercised when considering extremely high concentrations of low-income patients because other cost-increasing factors may be reflected in these estimates and the Congress might or might not want to account for them in the PPS rates.

If the Congress does want to adjust the PPS rates to reflect higher costs related to serving high proportions of low-income patients, several issues must be resolved. Two of the most important are which measure of low-income patients is used, which depends on the underlying goal you are trying to achieve; and whether to follow the cost analyses closely or design a smoother adjustment so that similar hospitals would be treated much the same way.

Picking up at the middle of page 11 of the prepared statement, four specific options, which are described in table 1, are analyzed here to illustrate some of the choices that are available to the Congress. The first two examples are based on the share of the low-income Medicare patients only, to reflect the concern for costs arising from severity of illness. Option 1 would follow the cost analyses quite closely by providing adjustments for just over 800 urban hospitals with 100 beds or more that serve at least 15 percent low-income Medicare patients. Two separate adjustments to the DRG rates would be made—a 4.5-percent increase for hospitals with shares of low-income patients between 15 percent and 45 percent, and a 10-percent increase for hospitals with larger shares.

Option 2 would provide an adjustment regardless of size or location, but only for hospitals with exceptionally high proportions of low-income patients—55 percent or more. The relatively low level of the adjustments for these 300 hospitals—2.5 percent—reflects the fact that many smaller rural hospitals with high proportions of low-income patients do not have significantly higher costs.

The other two options are based on the measure of all low-income patients, thereby reflecting the concern about costs arising both from greater severity of illness and from higher staffing and overhead expenses. Option 3 would follow the cost analysis to some extent, by targeting payments to the group on which the impacts are concentrated—urban hospitals with 100 beds or more that

serve at least 15 percent low-income patients. The adjustment would be smoothed, however, starting at 2 percent for hospitals with a 15-percent share and increasing gradually to a maximum of 18 percent for hospitals serving 55 percent or more low-income patients.

The fourth option would be somewhat less targeted than the third because it would reimburse over 1,000 large hospitals located in both urban and rural areas. It would also be the smoothest of the adjustments examined here—gradually increasing from zero as the share of low-income patients rises above 15 percent, reaching a maximum of 13 percent for hospitals with shares of low-income patients of 45 percent or more. Using a smoothed adjustment, as in options 3 and 4, would reimburse some hospitals differently than the cost analyses suggest, however.

The CBO simulated the impact that the four illustrative options would have on components of the PPS, and on Federal outlays.

The first step we took was to estimate the indirect teaching payment using statistical analysis that allowed it to reflect the impact of all factors not now considered in determining PPS payment rates—that is, all factors other than case mix, the wage index, and urban-rural location. In this case, the indirect teaching adjustment would be 8.4 percent, compared with the current adjustment of 11.59 percent. This technical correction would have the same effect on payments under all four options, yielding savings of $510 million in fiscal year 1986, as shown in the top panel of table 2.

The middle panel of table 2 shows that the payments directly related to the four disproportionate share adjustments would range from a low of $10 million for option 2 to a high of $370 million for option 3, both numbers for fiscal year 1986. If a disproportionate share adjustment were to be made, however, a related reduction in the indirect teaching adjustment of between 0.2 percent and 1.7 percent would be required to avoid double payment. The resulting cut in indirect teaching payments would depend on the extent to which the specific disproportionate share adjustments were targeted toward teaching hospitals. In these four examples, the correction would range from $50 million to $250 million in fiscal year 1986.

The bottom panel of table 2 shows the net budgetary impact of all three aspects of the options examined here; namely, reductions in payments to hospitals of $300 to $550 million in fiscal year 1986. These options would redistribute Federal PPS payments among hospitals in the expected way. Table 3 shows these impacts as well as those that would result if the budgetary effects that are shown in the middle panel of table 2 were offset in this particular example by an overall reduction in the DRG rate for all hospitals.

In conclusion, Mr. Chairman, the Congress has expressed interest in adjusting the Medicare prospective payment system to recognize the higher cost of serving a disproportionate share of low-income patients. There are many ways in which the Congress might implement such an adjustment, so many choices would have to be made—most notable among them is which sources of higher costs are to be compensated. Moreover, designing a specific disproportionate share adjustment would require several trade offs—for ex-

ample, between closely following the estimated cost impacts and treating similar hospitals in a similar way.

Thank you very much. I would be pleased to answer any questions you may have.

Senator DURENBERGER. Thank you for your testimony.

[The prepared written statement of Ms. Gordon follows:]

Statement of

Nancy M. Gordon
Assistant Director for
Human Resources and Community Development
Congressional Budget Office

before the
Subcommittee on Health
Committee on Finance
United States Senate

July 29, 1985

This statement is not available for public release until it is delivered at 1:30 p.m. (EDT) on Monday, July 29, 1985.

Mr. Chairman, there is widespread concern that hospitals serving a disproportionately large share of low-income patients are placed at a disadvantage under Medicare's Prospective Payment System (PPS), which does not directly adjust for the potentially higher costs incurred in treating such patients. Many people fear that if additional payments are not made to these hospitals, they might be placed under financial stress or they might undertreat or refuse to treat low-income Medicare patients.

This testimony addresses two main issues:

- o The effect of serving a large proportion of low-income patients on a hospital's costs for treating Medicare beneficiaries; and
- o Options for modifying Medicare's PPS to reflect these costs.

BACKGROUND

The Social Security Amendments of 1983 established the current prospective payment system under which Medicare compensates hospitals for inpatient services provided to its beneficiaries. The basic goal was to introduce incentives for efficient delivery of health services by restricting reimbursement differentials to those related to unavoidable differences in costs, and thereby to slow the growth in Medicare's payments for hospital care. Payment rates are now set in advance for 468 diagnostic categories, known as diagnosis-related groups (DRGs); thus, hospitals must bear the loss if their costs exceed these amounts. After a phase-in period--during which the prospective rates are based on a combination of regional, national, and hospital-specific amounts--the system will only have national rates,

calculated separately for urban and rural areas. These rates will, however, continue to be adjusted for area wage levels and for the size of any teaching program. The latter is called the indirect teaching adjustment.

While the current system does not contain a separate adjustment for hospitals with a disproportionately large share of low-income patients (often called "disproportionate share" hospitals), the Congress took a first step in this direction when it structured the indirect teaching adjustment. Teaching hospitals now receive twice the increment to their payment rates that was originally estimated as necessary to compensate them for higher costs related to their teaching programs. This doubling was justified as an interim step to pay for a variety of legitimate factors not otherwise accounted for by the PPS--including severity of illness, inner city location, and disproportionate share of low-income patients--all of which are associated with large teaching hospitals.

Several legislative actions, however, have indicated the Congress' concern for an improved adjustment that would be better targeted. The Social Security Amendments of 1983 gave the Secretary of the Department of Health and Human Services (HHS) the authority to modify payments under the PPS to take into account the special needs of public and other hospitals that serve a high proportion of Medicare beneficiaries or of patients who have low incomes. In addition, the Deficit Reduction Act of 1984 directed the Secretary of HHS to publish a definition of disproportionate share hospitals and to provide the Congress with a list of hospitals meeting this

criterion. Recently, the House Ways and Means Committee approved a bill that would make a specific "disproportionate share" adjustment to the PPS rates.

THE RELATIONSHIP BETWEEN THE SHARE OF LOW-INCOME PATIENTS AND HOSPITAL COSTS

There are two distinct sources of potentially higher costs for hospitals that treat a large share of low-income patients:

- Greater severity of illness for low-income Medicare patients within a given DRG; and
- Higher operating and overhead costs that result from two factors--meeting the special needs of both elderly and nonelderly low-income patients and the hospital's location.

Low-income Medicare patients have longer hospital stays and higher treatment costs than higher-income beneficiaries within the same DRG, possibly because of being in poorer health and possibly because of having fewer alternatives to the hospital for convalescence. Preliminary findings from a Congressional Budget Office (CBO) analysis of Medicare claims in 33 high-volume DRGs, which account for 46 percent of Medicare discharges, suggest that low-income patients, on average, stay in the hospital about 6 percent longer than their higher-income counterparts in the same DRGs.

In addition, hospitals that serve a large share of low-income patients--whether Medicare beneficiaries or others--may also incur higher costs because they provide specialized services to meet these patients' needs.

These hospitals may employ additional staff--for example, nutritional technicians and language interpreters--relative to hospitals with higher-income patients. They may also be more likely to incur higher overhead costs related to special departments, such as social work services, and to be located in areas where more security services are necessary.

Possible Measures of a Hospital's Share of Low-Income Patients

Measures of a hospital's share of low-income patients are relevant to estimating the impact on hospital costs and to designing an adjustment to PPS rates. The two potential sources of higher hospital costs--greater severity of illness, and special operating and overhead costs--give rise to two corresponding conceptual measures of a hospital's share of low-income patients:

- The proportion of a hospital's **Medicare** patient load that is low-income; and
- The proportion of a hospital's **total** patient load that is low-income. 1/

Unfortunately, direct information on patients' incomes is not available from either hospital records or Medicare claims and enrollment files. Therefore, the income levels of a hospital's patients must be measured indirectly.

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1. In either case, patient load could refer to the number of patients or to the number of days of care.

One indirect indicator of low income among Medicare patients is whether or not the Medicare Supplementary Medical Insurance (SMI) premium is directly paid for a beneficiary by a state Medicaid program. Medicaid "buy-in" status is available from the Medicare enrollment files and could be used without delay. It is important to note, though, that it would not be strictly comparable across states because of differences in the income-eligibility requirements for Medicaid. 2/

If, instead, the Congress wishes to adjust for costs attributable to all low-income patients, then some measure of nonMedicare low-income patients must also be used. One possibility is the number of nonMedicare patients for whom Medicaid is the primary payer. This measure is presently available from the American Hospital Association and is being collected by the Health Care Financing Administration (HCFA) as part of the 1984 Medicare Cost Report from each hospital. While it is also imperfect, again because of varying income eligibility requirements among the states, no

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2. The principal basis for Medicaid eligibility among Medicare beneficiaries is receipt of Supplemental Security Income (SSI). Because about half the states supplement the federally guaranteed benefit levels, people with higher incomes are eligible for Medicaid in some states but not in others. The extreme case is California, where the maximum benefit is about twice the federally guaranteed level. In addition, "medically needy" programs in about two-thirds of the states provide eligibility for individuals meeting all the SSI requirements except that their incomes are somewhat too high. Many medically needy recipients qualify because they have large medical expenses relative to their incomes. These patients are more severely ill, but have somewhat higher incomes than the typical Medicaid recipient.

currently available alternative appears to be better. 3/

Findings on Hospital Costs

The CBO estimates that both measures of the proportion of a hospital's patients who have low incomes--the one for Medicare patients only and the one for all low-income patients--are associated with significantly higher costs for treating Medicare beneficiaries. 4/ There appear to be two thresholds at which the cost impacts manifest themselves, as shown in Figure 1. The first threshold is at about 15 percent of patients having low incomes--which corresponds to the median hospital's low-income share under either measure; the second is at an extremely high concentration of low-income patients--55 percent and above. There is a

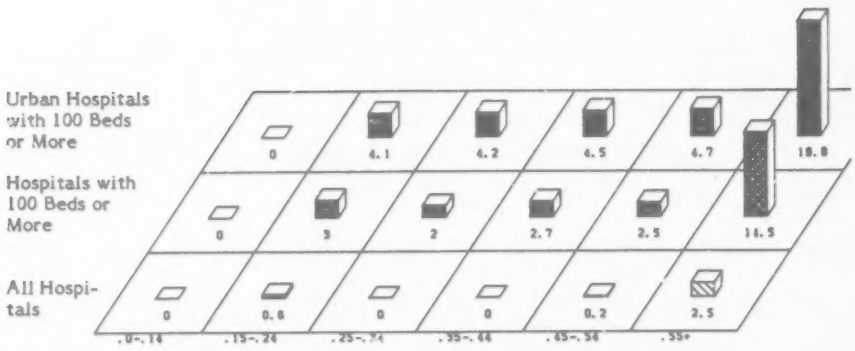
3. Although the number of nonelderly Medicaid patients could be adjusted by an index designed to measure the relative expansiveness of state Medicaid eligibility policies, this would not yield an accurate hospital-specific measure, because the distribution of the Medicaid-ineligible, low-income population varies within states and across hospitals within communities. The CBO is currently examining possible modifications that would vary among geographic areas within states, but these analyses are not yet complete.

   Another adjustment would be to include bad-debt and charity care, but this approach could not be implemented quickly because such information is confidential and is not reported by all hospitals. Moreover, the lack of uniform accounting principles to measure bad-debt and charity care means that, for some hospitals, these categories include charges for some higher-income patients.

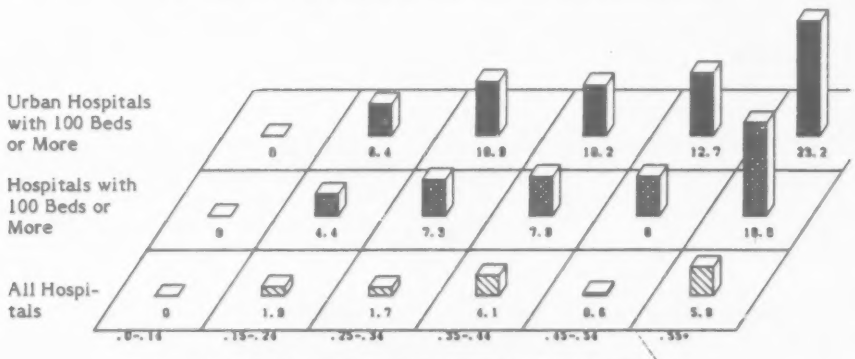
4. These results are based on multivariate regression analyses that account for the effects on costs of other factors such as the area's wage level and the hospital's case mix, size of teaching program, location, and number of beds, as well as whether or not it is a public hospital. Costs were measured by Medicare's allowable amounts as reported on the Medicare Cost Reports for 1981, the same data as used to develop the DRG payment system.

FIGURE 1

RELATIONSHIP BETWEEN SHARE OF LOW-INCOME PATIENTS AND HOSPITAL COSTS a/



Medicaid Buy-In Days as a Proportion of All Medicare Days



Medicaid Buy-In Days and Other Medicaid Days as a Proportion of All Days

SOURCE: Congressional Budget Office analysis based on data from the 1981 Medicare Cost Reports, the Medicare History Sample File for 1974 to 1981, and the 1981 American Hospital Association Annual Survey of Hospitals.

a. Shaded blocks and corresponding figures represent the percent increase in Medicare's cost per discharge relative to similar hospitals serving less than 15 percent low-income patients.

modest increase in costs at the first threshold--less than 5 percent using the Medicare-only measure and between 2 percent and 12 percent using the combined Medicare-Medicaid measure. But a substantially larger effect--up to 20 percent and more--occurs at the second threshold. Most of the cost impact occurs in urban hospitals with 100 beds or more. The CBO's analyses show little or no increase in costs for small urban hospitals or for rural hospitals.

Because it is not possible to be certain that the relationship between concentrations of low-income patients and higher hospital costs is solely caused by the factors discussed above, these estimates should be used with caution. Particular care should be exercised when considering extremely high concentrations of low-income patients because other cost-increasing factors may be reflected in these estimates and the Congress might or might not want to account for them in the PPS rates.

ISSUES AND OPTIONS

This section examines the issues the Congress must resolve, should it wish PPS payments to reflect costs related to serving a disproportionate share of low-income patients, and then analyzes four specific alternatives. All of the options would have two aspects--modifying the current indirect teaching adjustment and adding a new adjustment that would be more directly related to the share of a hospital's patients with low incomes.

Issues in Designing An Adjustment

The principal decision for the Congress--if it chooses to adjust the PPS rates for disproportionate share--is whether to pay only for costs related to treating low-income Medicare beneficiaries, or to reflect costs attributable to staff and facilities serving all low-income patients in the hospital. Proponents of the former approach contend that Medicare should be responsible only for costs directly associated with treating Medicare beneficiaries. Supporters of the latter approach point out that, because cost-accounting methods do not allow all costs to be allocated to specific patients, Medicare paid for a portion of the special operating and overhead costs associated with serving low-income nonMedicare beneficiaries under the previous cost-reimbursement system. Moreover, they argue that these costs are beyond the hospitals' control and hence should be reflected in the PPS rates.

Even after this basic decision has been made, however, several other issues remain. Perhaps the most important concerns how closely an adjustment should follow the empirical cost analyses shown above. The underlying rationale of the PPS argues for reflecting differences in average costs attributable to serving high concentrations of low-income patients, but several other factors might lead the Congress to diverge from precisely following the cost relationships.

For example, the Congress would have to define "disproportionate"--that is, it would have to specify the concentration of low-income patients at

which an adjustment would be made. Extra payments might be made to all hospitals for which analyses show any cost impact, or the adjustment might be restricted to those for which the impact is substantial.

An important consideration in making this decision is that similar hospitals should be affected in similar ways, which suggests that hospitals just below any threshold for an adjustment not be paid significantly less than those just above it. Especially in view of the data limitations described above, an adjustment might be "smoothed" over adjacent ranges of disproportionate share-values, rather than reflecting the sharply different amounts from the cost analyses, but then hospitals would receive payments that differed from the estimates of the costs they actually experience.

Another issue is how to minimize unintended behavioral responses. For example, an adjustment classification that would only pay hospitals above a certain size might induce slightly smaller ones with large low-income patient loads to expand. This possibility could be minimized, however, by choosing any size cutoffs so that there were relatively few hospitals that were only slightly smaller. 5/

Maintaining consistency with other aspects of the PPS would require careful examination of the relationship between any disproportionate share

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5. In addition, state "certificate of need" laws that regulate growth in the numbers of hospital beds and other forms of capital might limit strategic reactions of this sort.

adjustment and the indirect teaching adjustment because the latter was intended, in part, to perform the function of a disproportionate share adjustment. Finally, ease of administration would argue for an adjustment that would be easy to calculate and that would be based on accurate, easily audited, and relatively up-to-date measures of a hospital's share of low-income patients.

Specific Options

A variety of reasonable disproportionate share adjustments could be designed that would reflect differing judgments on the issues discussed above. Four specific ones, described in Table 1, are analyzed here to illustrate some of the choices available to the Congress. The first two examples are based on the share of low-income Medicare patients only, to reflect the concern for costs arising from severity of illness. Option 1 would follow the cost analyses quite closely, by providing adjustments for just over 800 urban hospitals with 100 beds or more that serve at least 15 percent low-income Medicare patients. Two separate adjustments to the DRG rates would be made--a 4.5 percent increase for hospitals with shares of low-income patients between 15 percent and 45 percent, and a 10 percent increase for hospitals with larger shares. These amounts and ranges would not exactly parallel the cost analyses, however, to reflect the concern that the estimated cost impact for hospitals with extremely high concentrations of low-income patients--almost 20 percent--is actually being raised by other factors, as discussed earlier.

TABLE 1. CHARACTERISTICS OF FOUR ILLUSTRATIVE OPTIONS FOR A DISPROPORTIONATE SHARE ADJUSTMENT AND RELATED CHANGES IN THE INDIRECT MEDICAL EDUCATION ADJUSTMENT

	Option 1	Option 2	Option 3	Option 4
Definition of Low-Income Share	Inpatient days of Medicaid buy-ins as a percent of all Medicare inpatient days	Inpatient days of Medicaid buy-ins as a percent of all Medicare inpatient days	Inpatient days of Medicaid buy-ins and other Medicaid patients as a percent of total hospital inpatient days	Inpatient days of Medicaid buy-ins and other Medicaid patients as a percent of total hospital inpatient days
Eligible Group	Urban hospitals with 100 beds or more and low-income share of 15 percent or more	All hospitals with low-income share of 55 percent or more	Urban hospitals with 100 beds or more and low-income share of 15 percent or more	All hospitals with 100 beds or more and low-income share of 15 percent or more
Increase in DRG Rates for Disproportionate Share	4.5 percent for low-income share between 15 percent and 45 percent; 10 percent for share of 45 percent or more	2.5 percent	2 percent plus 4 percent for each 10 percentage point increase in low-income share above 15 percent	4.3 percent for each 10 percentage point increase in low-income share above 15 percent
Maximum Adjustment	10 percent	2.5 percent	18 percent	13 percent
Number of Hospitals That Would Receive Disproportionate Share Adjustment a/	830	330	780	1,060
Resulting Indirect Medical Education Adjustment b/	7.8 percent c/	8.2 percent c/	6.7 percent c/	7.0 percent c/

SOURCE: Congressional Budget Office.

a. The figures shown include 330, 30, 380, and 360 teaching hospitals, respectively.

b. This adjustment would be paid to approximately 900 teaching hospitals.

c. Percent increase in the federal portion of hospital payments related to a 10 percent increase in the ratio of interns and residents to beds.

Option 2 would provide an adjustment regardless of size or location, but only for hospitals with exceptionally high proportions of low-income patients--55 percent or more. The relatively low level of the adjustment for these 300 hospitals--2.5 percent--reflects the fact that many smaller, rural hospitals with high proportions of low-income patients do not have significantly higher costs.

The other two options are based on the measure of all low-income patients, thereby reflecting the concern about costs arising both from greater severity of illness and from higher staffing and overhead expenses. Option 3 would follow the cost analysis to some extent, by targeting payments to the group on which the impacts are concentrated--urban hospitals with 100 beds or more that serve at least 15 percent low-income patients. (About 60 percent of these hospitals would also be eligible under Option 1 which is based on the other measure of low income.) The adjustment would be smoothed, however, in order to reflect the pattern of cost impacts found using this measure of low-income patients. It would start at 2 percent for hospitals with a 15 percent share and then increase gradually to a maximum of 18 percent for hospitals serving 55 percent or more low-income patients.

The fourth option would be somewhat less targeted than the third, because it would reimburse over 1,000 large hospitals, located in both urban and rural areas. It would also be the smoothest of the adjustments examined

here--gradually increasing from zero as the share of low-income patients rises above 15 percent, reaching a maximum of 13 percent for hospitals with shares of low-income patients of 45 percent or more. Using a smoothed adjustment, as in Options 3 and 4, would reimburse some hospitals differently than the cost analyses suggest, however.

Impacts on Components of the PPS and on Federal Outlays

The CBO simulated the impact that the four illustrative options would have on components of the PPS. The indirect teaching payment was initially estimated by statistical analysis, which allowed it to reflect the impacts of all factors not now considered in determining PPS payment rates--that is, all factors other than the case mix, the wage index, and urban-rural location. In this case, the indirect teaching adjustment would be 8.4 percent, compared with the current adjustment of 11.59 percent. This technical correction would have the same effect on payments under all four options, yielding savings of $510 million in fiscal year 1986, as shown in the top panel of Table 2.

The payments directly related to the four specific disproportionate share adjustments would range from $10 million to $370 million in fiscal year 1986, reflecting the differing number of hospitals that would be eligible and the differing increases that would occur in their DRG rates (see the middle panel of Table 2). If a disproportionate share adjustment were to be

TABLE 2. IMPACTS OF ILLUSTRATIVE OPTIONS ON COMPONENTS OF MEDICARE'S PPS OUTLAYS (In millions of dollars) a/

	1986	1987	1988	Cumulative 1986-1988
Technical Correction to Indirect Teaching Adjustment b/				
All Options	-510	-750	-1,020	-2,290
Option 1				
Disproportionate Share Adjustment	300	440	600	1,340
Additional Correction to Indirect Teaching Adjustment c/	-90	-130	-170	-390
Subtotal	**210**	**310**	**430**	**930**
Option 2				
Disproportionate Share Adjustment	10	15	20	50
Additional Correction to Indirect Teaching Adjustment c/	-50	-70	-90	-205
Subtotal	**-40**	**-55**	**-70**	**-155**
Option 3				
Disproportionate Share Adjustment	370	540	730	1,630
Additional Correction to Indirect Teaching Adjustment c/	-250	-370	-490	-1,110
Subtotal	**120**	**170**	**240**	**520**
Option 4				
Disproportionate Share Adjustment	280	420	560	1,270
Additional Correction to Indirect Teaching Adjustment c/	-200	-300	-400	-910
Subtotal	**80**	**120**	**160**	**360**
Net Budgetary Impact				
Option 1	-300	-440	-600	-1,340
Option 2	-550	-800	-1,090	-2,440
Option 3	-400	-580	-790	-1,770
Option 4	-430	-640	-860	-1,930

SOURCE: Congressional Budget Office.

a. Negative entries denote savings. Details may not add to totals due to rounding.

b. Reduction in the indirect teaching adjustment from 11.59 percent to 8.4 percent.

c. Additional reduction from 8.4 percent to reflect payments made in accordance with the various disproportionate share adjustments.

made, however, a related reduction in the indirect teaching adjustment of between 0.2 percent and 1.7 percent would be required to avoid double payment. The resulting cut in indirect teaching payments would depend on the extent to which the specific disproportionate share adjustment were targeted toward teaching hospitals. In these four examples, corrections would range from $50 million to $250 million in fiscal year 1986, partially offsetting, and in one case exceeding, the direct disproportionate share payments.

The net budgetary impact of all three aspects of the options examined here would be reductions in Medicare PPS payments to hospitals of $300 million to $550 million in fiscal year 1986, as shown in the bottom panel of Table 2. Cumulative reductions over fiscal years 1986 to 1988 would range from $1.3 billion to $2.4 billion.

If the Congress were to make a disproportionate share adjustment and combine it with the corresponding correction to the indirect teaching adjustment, there would be some redistributions of federal PPS payments among hospitals, as shown in the upper panel of Table 3. 6/ As expected, major teaching hospitals--especially those not serving a disproportionate share of low-income patients--would generally lose, with the federal portion

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6. These estimates do not reflect the impact of the technical correction in the indirect medical education adjustment from 11.59 percent to 8.4 percent.

TABLE 3. IMPACT ON THE FEDERAL PORTION OF PPS PAYMENTS UNDER FOUR ILLUSTRATIVE DISPROPORTIONATE SHARE OPTIONS, BY TYPE OF HOSPITAL (In percent, fiscal year 1986) a/

	Option 1	Option 2	Option 3	Option 4
Disproportionate Share Adjustment and Further Indirect Teaching Reduction Only				
Overall Change in Federal Outlays a/	210	-40	120	80
Disproportionate Share Hospitals b/				
Major teaching c/	+1	-3	e/	-1
Minor teaching d/	+4	+1	+3	+2
Nonteaching	+4	+2	+5	+4
Nondisproportionate Share Hospitals				
Major teaching c/	-2	-4	-5	-4
Minor teaching d/	e/	-1	-1	-1
Nonteaching	0	0	0	0
Disproportionate Share Adjustment, Further Indirect Teaching Reduction, and Change in DRG Rates for Budget Neutrality				
Overall Change in Federal Outlays a/	0	0	0	0
Disproportionate Share Hospitals b/				
Major teaching c/	f/	-2	-1	-1
Minor teaching d/	+3	+1	+3	+2
Nonteaching	+4	+3	+5	+3
Nondisproportionate Share Hospitals				
Major teaching c/	-3	-4	-6	-5
Minor teaching d/	-1	e/	-2	-1
Nonteaching	-1	+1	e/	e/

SOURCE: Congressional Budget Office.

a. These estimates do not reflect the impact on payments of the technical correction in the indirect medical education adjustment from 11.59 percent to 8.4 percent.

b. For definitions and numbers of hospitals, see Table 1.

c. Hospitals with ratios of interns and residents to beds exceeding 0.25.

d. Hospitals with ratios of interns and residents to beds up to 0.25.

e. Decline in reimbursements of less than 0.5 percent.

f. Increase in reimbursements of less than 0.5 percent.

of their 1986 PPS payments falling by as much as 3 percent to 4 percent. Minor teaching hospitals would gain or lose, depending upon their eligibility for the disproportionate share adjustment. Nonteaching hospitals receiving an adjustment would gain up to 4 percent or 5 percent, while the others would not be affected by either aspect of these options.

Because of current fiscal pressures and to be consistent with the overall design of the PPS, the Congress might also want to consider a further adjustment to the DRG rates that would eliminate the budgetary effect of a disproportionate share adjustment and its related correction to the indirect teaching adjustment. One way this objective could be accomplished for Options 1, 3, and 4 would be to lower the DRG rates for all hospitals. 7/ The resulting distributional effects under the four illustrative options are shown in the lower panel of Table 3. The pattern of payment changes would be quite similar to that described above, with the magnitudes changed only slightly. The general effect would be to lower some gains and increase some losses, but usually by only a fraction of a percent.

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7. Another approach would be to lower the DRG rates for only one group of hospitals. For example, if a disproportionate share adjustment were targeted to urban hospitals, only the rates for all urban hospitals might be cut. Note also that, under Option 2, the further correction to the indirect teaching adjustment would lower payments by more than the increase that would directly result from the disproportionate share adjustment. Consequently, achieving budget neutrality in this case would require raising DRG rates.

CONCLUSION

Mr. Chairman, the Congress has expressed interest in adjusting the Medicare prospective payment system to recognize the higher costs of serving a disproportionate share of low-income patients. There are many ways in which the Congress might implement such an adjustment and, hence, many choices would have to be made--most notable among them is which sources of higher costs are to be compensated. Moreover, designing a specific disproportionate share adjustment would require several trade-offs, for example, between closely following the estimated cost impacts and treating similar hospitals in a similar way.

Senator DURENBERGER. On page 8 of your testimony you caution us against relying on your estimates in regard to hospitals with extremely high concentrations of low-income patients. Would you give us some idea of what you call the other cost increasing factors are that would cause you to raise this caution flag?

Ms. GORDON. The state of knowledge at this time is that we are not sure what those other factors are. We note that there is a dramatic increase in coefficients for the hospitals that have shares of 55 percent or more. I think analysts always get nervous when numbers jump by that much. We would be pleased to look into this issue more over the next few weeks. I think your staff has indicated some interest in our doing that.

Senator DURENBERGER. And you heard me earlier raise the issue with Carolyne about cost shifting. When you hear about the size of the uncompensated care burden in this country and you know that it's getting larger, you know that hospitals are looking anywhere they can to do some shifting. If you can also help us explore the degree to which there is some cost shifting to Medicare from uncompensated care, from bad debts, from whatever, that would certainly be helpful to us.

Ms. GORDON. We would be pleased to follow up with your staff on that issue as well.

It has occurred to me that, if one is going back to 1981 when the cost-based reimbursement system was in effect, Medicare has always followed a principle of paying for costs attributable to Medicare patients only. And so I think the opportunities of hospitals to shift cost at that time were limited and that Dr. Davis' point about there being little incentive to do that under the DRG system may be correct.

Senator DURENBERGER. Your data appears to show that Medicare costs per case falls in rural hospitals until you reach very high concentrations of low-income patients. Do you have any idea of why that's the case?

Ms. GORDON. When we look at our various analyses the coefficients are relatively small. Some of them are insignificant. For the rural hospitals, there is quite a bit of variability. Thus our conclusion is that we are not sure whether there is no cost increase or a slightly lower cost, but there is not a cost increase.

Senator DURENBERGER. On the issue of the dual eligibles, if we were interested in proceeding with a disproportionate share adjustment this year, apparently we can't get all the dual eligible. At least we have only 80 percent of the information we need. Do you have some suggestions about how we might fix the problem of not having information in States like Oregon and others?

Ms. GORDON. I think that part of the problem is a short-term one because States like Oregon and Louisiana have made a decision to have Medicaid buy its recipients into the Medicare system. Therefore, we will have that data in the future. One possibility that you could consider would be to structure an interim mechanism for those four States, and then when the data are available——

Senator DURENBERGER. There are four States that are involved?

Ms. GORDON. I believe that there are four States who have in the past not had Medicaid buy in their Medicare eligible recipients, three of which have since decided to move ahead and make that change. But because that decision is not yet in place in all of those States and because data lags, the information is not available now.

But the intermediaries could do the calculations when the data was available and then retrospectively work it out to make sure that in the end Medicare had only paid that which it should have paid.

Senator DURENBERGER. I think you have cautioned us not to go down the dual eligible track alone, and that really was insufficient.

Ms. GORDON. As you know, CBO never recommends a particular policy to the Congress. I think that that choice really depends on what it is that you want the PPS system to compensate for. Do you want to look only at the number of low-income Medicare patients? Or do you want to continue what the previous cost reimbursement system did, which is to pay for a portion of the overhead costs that are not really directly attributable to a specific patient?

Senator DURENBERGER. All right.

All of the proxies that we have been looking at appear to be, at best, crude. HCFA is undertaking a major initiative to look at an adjustment factor which is based on the percent of elderly poor by ZIP Code, using census data. Can you venture any kind of guess as to how good an instrument that might be? Or are there other measures that might be equally as good or better?

Ms. GORDON. I think that we have some hope for that it could produce a usefull alternative, because it is based upon a narrower geographic area. The problem with the State adjusters is that a State is so large and there is so much variability within that State. On the other hand, this measure would only consider the locations of elderly patients, and not all low-income patients. If you would like us to take a look at this during the coming weeks, we would be pleased to.

Senator DURENBERGER. I think it would be helpful because it strikes me that we have to get off of this paying on the basis of people who qualify for certain programs. There is the gentleman

sitting right over there who used to run Parklawn and now runs the University of Texas Hospital. And he isn't going to make it at all if we stick just with Medicaid.

And there are a lot of people similarly situated around this country. So we are looking for something else. I had originally looked for something where we would let somebody else make the decision. Send the money back to the same people that make some of the income-maintenance decisions. But I was told there is really no way to do that. So if Congress is left with the decisionmaking, I think we need to have it aimed more at something that isn't program oriented.

Ms. GORDON. Yes. I think there is some potential for taking the route that HCFA has proposed.

Senator DURENBERGER. Well, thank you very much for your testimony. I appreciate it a great deal.

Gentlemen, thank you also.

Ms. GORDON. Thank you.

Senator DURENBERGER. Our next witness is Dr. Stuart Altman, chairman of the Prospective Payment Assessment Commission. Stu, we appreciate very much you being here, and all of the tough work you have had to put in over the last couple of years, putting PROPAC together and then keeping it on its course while getting all kinds of advice from some of us as to what that course really ought to be. But you have taken a position on disproportion share hospitals, which the make up of your Commission would indicate that you probably would. And we appreciate that a great deal. Your full statement on the subject will be made part of the record, and you may proceed now to summarize that statement.

STATEMENT OF DR. STUART ALTMAN, CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, WASHINGTON, DC

Dr. ALTMAN. Thank you, Mr. Chairman. This is a pleasure. This is the first opportunity I have had to come before this subcommittee as the chairman of the Prospective Payment Assessment Commission. I would like to introduce Bruce Steinwald, to my right, who is deputy director of our staff and did much of the analytical work that went into our findings.

As you indicated, we have had an active year and a half since the Commission got going. And soon after beginning our efforts, we took very seriously the charge which this committee helped to draft to establish PROPAC, that we should try to work as hard as we could to make sure that the prospective payment system worked fairly and equitably and that we should work very diligently to make sure that in implementing a new reimbursement system we did not see the equity of our system deteriorate or access to care diminish for certain subgroups of our population.

And in that vein we came upon the issue of the disproportionate share hospital. It was the Commission's feeling that it was not appropriate for us to simply make a recommendation on what kind of an update factor there should be with respect to the annual increase in the PPS rates without making sure that the dollars flowed equitably. And the issue of those hospitals that treat a disproportionate share of low-income populations came to the fore of

the Commission. At that point, we asked our staff to take a hard look at the issue of whether a hospital's Medicare costs are higher just because of a significant low-income population. And I, too, would like to support the three cardinal rules that you have used in discussing this issue.

We are talking not about uncompensated care, as important an issue as that is. We are talking about the extent to which low-income populations in a hospital are really a proxy for something going on in that hospital which leads to higher Medicare costs which are not being paid through our existing PPS system.

And I have tried to make that point a number of times, and I am sure you have too. It's so easy for people to fall into the trap of saying "oh, you are just dealing with the low-income population issue because you want to deal with the incompensated care problem." That is not the intent of the Commission, and it is surely not my recommendation.

To the extent that they work in parallel, however, that's the nature of the complications of our system.

The staff compiled and analyzed the relevant studies before we completed our report. And as you remember, in our report to the Secretary, we made it very clear that an adjustment for disproportionate share was appropriate and should be made by the time the 1986 rates went into effect.

We recognized, however, that holding up this issue was the absence of a clear definition. The Secretary had indicated on more than one occasion, as Dr. Davis indicated today, that the Department lacked an appropriate definition for the low-income population or disproportionate share hospitals and, therefore, they couldn't make the adjustments.

We were sympathetic to the problem, but we were not sympathetic to using that as an excuse, if you will, for not moving forward.

At that point, the Commission urged its staff to work with HCFA and others both in Washington and outside to develop the foundation for an adjustment. And they did do that. The staff assembled a group and worked closely with representatives of the American Hospital Association, the D.C. Hospital Association, the National Association of Public Hospitals, the Health Care Financing Administration, the Congressional Budget Office and the Congressional Research Service, as well as other interested parties.

Now I mentioned these groups not because they necessarily agree with the Commission's recommendation, but this was as close as we could come to doing the job you asked us to do. And that was to assemble the expert information on an issue of relevance.

Our current results further emphasized that our initial set of recommendations were on the mark. It is true—and no evidence we have been able to see of late will argue to the contrary—that those hospitals that treat a disproportionate share of low-income population, particularly urban hospitals, do have higher Medicare costs. As the representatives of both CBO and HCFA have said, we don't know exactly why. We can infer a lot of reasons, however. Some of them we are pretty clear about. There is a wage factor that tends to work against them. There are other costs, such as security requirements, of running a hospital in a large, urban area. There are

other costs when you are dealing with low-income populations, as you indicated in your opening statement, such as drug abuse and other problems that don't fit neatly into the medical paradigm. There are significant severity variations, which, as you pointed out as well, have not been addressed as yet in the current PPS system.

So when you pull all the studies together, the evidence is overwhelmingly supportive of an adjustment. And then we come down to the technical question—how to make it work and how to make it work fairly.

I'm not here to tell you that we have come up with the best adjustment that is without fault. As a matter of fact, you will bring groups up here, and they might come up with four different answers.

But I think it's a mistake, if you will excuse me, to allow what on the margin are small changes in the definition to delay an important adjustment. We have been prepared to adjust the system before. If new information becomes available in later years, the adjustments can be modified.

In that context, let me give you our best shot, recognizing that this is just a recommendation. Our staff would be willing to work with your staff and others to make it work better.

We did look at several disproportionate share measures, and I won't go into them again, and decided that, based on the information we have seen, the best measure was to take the Medicaid population in a hospital, combine it with the Medicare-Medicaid crossover group that we talked about before, and then make an adjustment to account for the fact that in some States Medicaid pays a relatively small percentage of the low-income population's bill. Each hospital's Medicaid patient proportion would be adjusted to reflect State variations in the extent to which Medicaid provides coverage to the States' low-income population.

Now we went one step further, because that adjustment, left alone, could benefit some hospitals that really treat a very small percent of low-income populations. And it could also penalize some States where they not only have a very good Medicaid Program, as in my State of Massachusetts, but also have an uncompensated care problem which they address. And, therefore, based on the evidence we amassed, we came up with a threshold measure. This threshold of a minimum proportion of Medicaid patients would be reached before the adjustment would come into play.

Now what that threshold should be is a subject for discussion. Right now, our estimates indicate that the threshold should be set so that an adjustment would be paid to urban hospitals with 100 beds or more and a substantial proportion of Medicaid patients. This would eliminate a lot of the hospitals who would wind up getting, if you will, a bonus that they don't deserve; and we would focus our limited dollars on those that are really most in need.

I want to emphasize that in all our discussions we are talking about a budget-neutral adjustment. We believe that these are dollars that have been taken out of the original cost system and redistributed under PPS away from the disproportionate share hospitals. And, therefore, if you put these dollars back in the disproportionate share hospitals, some mechanisms should be developed to take the money from the total.

So, again, let me just summarize this adjustment for three hospitals that treat a disproportionate share of low-income population. It is badly needed. We believe it should be implemented before the 1986 rates go into effect. PROPAC, CBO, and others have come up with different techniques, none of which is perfect, but which go a long way to bringing more equity to the PPS system and to providing the level of access that is needed. And, finally, this should be done in a budget-neutral way.

We, of course, would be willing to continue work on this subject. We think it is critical to our mandate, and we appreciate the opportunity of coming here this afternoon.

Senator DURENBERGER. Stuart, thank you for that excellent summary.

[The prepared written statement of Dr. Altman follows:]

TESTIMONY

Before The

HEALTH SUBCOMMITTEE

COMMITTEE ON FINANCE

U.S. SENATE

July 29, 1985

For The
PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Stuart Altman, Ph.D.
Chairman
Prospective Payment Assessment Commission

Summary

Testimony of
Prospective Payment Assessment Commission
by
Stuart H. Altman, Ph.D., Chairman

July 29, 1985

-Disproportionate Share Hospitals are a high priority concern of the Prospective Payment Assessment Commission. An adjustment for such hospitals was recommended in ProPAC's first report to the Secretary of Health and Human Services in April, 1985.

-At its meeting of July 17-18, 1985, the Commission reaffirmed its recommendation, in light of increasing budgetary constraints on the PPS system, and suggested an approach for the design of the adjustment.

-ProPAC considers this issue part of its responsibilities regarding recommendations for the annual update factor. ProPAC sees this as an issue of equitable distribution of prospective payment funds to hospitals.

-The definition of an adjustment for hospitals with a disproportionate share of low income patients should not be confused with a payment for uncompensated care. Rather, after review of the data, the Commission believes that Medicare costs are higher in certain hospitals which serve a high proportion of low income persons, and it is this situation which the recommended adjustment seeks to address.

-ProPAC assembled a technical advisory group to assist in the development of a specific adjustment. The Commission recommended at its recent meeting that the adjustment should be based on a proxy measure for low-income patients using data on elderly and non-elderly Medicaid recipients, adjusted to take into account differences in state Medicaid programs. The adjustment should be targeted to hospitals with a significant percentage of low-income patients whose Medicare costs are significantly affected by the presence of such patients.

-The Commission will continue to analyze this subject and monitor future actions. We will assist the Committee in whatever way is requested.

Introduction

Mr. Chairman, I am pleased to testify before you today on behalf of the Prospective Payment Assessment Commission. I am accompanied by Bruce Steinwald, Deputy Director of the staff of the Commission.

The subject of your hearing today, hospitals which serve the poor and the elderly, has been an area of priority concern for ProPAC during our first year. In our first report to the Secretary of Health and Human Services in April of this year, we recommended an adjustment in the Medicare Prospective Payment System (PPS) for disproportionate share hospitals. The Commission further recommended that the Secretary develop a definition and methodology for disproportionate share hospitals so that the PPS rates could be adjusted for the fiscal year 1986. The Commission urged that any adjustments be budget neutral with respect to total prospective payments to hospitals.

At our most recent meeting on July 17-18, the Commission reiterated its support for a budget neutral adjustment. The Commission's commitment to this adjustment has intensified in the face of mounting evidence on this problem and increasing budgetary constraints on the prospective payment system. This recent recommendation, which I will describe in more detail later in this statement, suggests an adjustment which is based on a

proxy measure for low-income patients, contains a threshold limiting the adjustment to those urban hospitals with significant percentages of low-income patients, and is targeted to those hospitals having Medicare costs which are significantly affected by the presence of such patients. The Commission has directed its staff to continue its analytic and monitoring work in this area.

Commission's Work

I'd now like to review some of the considerations that have guided the Commission's work on disproportionate share hospitals. As you are aware, when this Committee authored the legislation creating our Commission, you asked that we concentrate our effort in two major areas. The first area requires us to develop recommendations for an annual "update factor," or rate of change in PPS rates, from one year to the next. The second major area requires the Commission to recommend changes needed in the DRG classification and weighting system.

The disproportionate share issue is considered by the Commission within the context of the update factor. Our reasoning for examining this issue is that a disproportionate share hospital adjustment, or the lack of such an adjustment, could have a substantial impact on the amount and equity of the payments made to certain hospitals. If hospitals serving a disproportionate

share of low-income patients incur higher Medicare costs due to more severely ill patients or for other reasons which are beyond the hospitals' control, and these higher costs are not recognized in the payment system, then these hospitals will be unfairly penalized. As a result, access to and quality of care for Medicare patients in these institutions could deteriorate over time.

The Commission began its investigation of this issue with a careful review of previous studies and analyses. At our request, a number of groups, including the Health Care Financing Administration, came before the Commission to present findings from their research and analysis. The Commission also requested its own staff to begin analytic work in this area last fall.

Disproportionate Share Hospitals and Uncompensated Care Question

The critical point of debate in previous studies centered around the question of whether it costs more to care for Medicare patients in hospitals which serve a high proportion of low-income patients than in hospitals which have a low proportion of such patients. This is the question to which the Commission has answered "yes." The question is not whether a PPS adjustment is provided to hospitals which provide a large amount of uncompensated care. That is, the Commission has not taken the position that hospitals with large amounts of care delivered to

those who do not or cannot pay should be considered disproportionate share hospitals and receive an adjustment to their PPS payments. Rather, ProPAC has studied the data and has come to the conclusion that Medicare costs are higher in hospitals which serve a high proportion of low-income persons. The precise reasons for these higher costs are not well understood. Based on its own studies, however, and those of other agencies and organizations, ProPAC is convinced that these higher costs per case are due primarily to factors beyond the control of hospitals. While it appears that a number of the hospitals which would receive a disproportionate share hospital adjustment do in fact have a large uncompensated care case load, the fact that the cases are uncompensated does not enter into our recommended measure of, or rationale for, a PPS adjustment.

ProPAC Staff Work

We indicated in the April report that we were convinced that hospitals serving a high volume of low income patients do incur higher Medicare costs per case. We noted that all studies, including those completed by the HCFA, indicated a consistent and significant positive relationship between Medicaid volume and Medicare cost per case. And we believed that, although a number of key issues concerning the definition of disproportionate share hospitals had not been settled, there was still adequate time for such work to be done so that equitable adjustment could

be made in time for incorporation into the proposed fiscal year 1986 regulations due in June.

Because of the high priority ProPAC accorded to this subject, the Commission requested its staff to continue and intensify analytic work in the area. Following the April report, ProPAC staff assembled an informal technical work group representing other organizations and individuals with expertise in this area. The group was composed of technically knowledgeable representatives from the American Hospital Association, D.C. Hospital Association, National Association of Public Hospitals, Health Care Financing Administration, Congressional Budget Office, and Congressional Research Service. The group met several times to discuss and review data related to specifying the relationship between alternative disproportionate share measures and Medicare cost per case. The recommended adjustment methodology which I will describe should not be construed as having the endorsement or support of all of those who participated. Rather, I have noted the group's contribution to indicate the substantial effort by ProPAC staff and others to assure the most technically well-informed process was followed in developing information and coming to a policy position by the Commission.

A major issue which the Commission needed to address in developing an adjustment was the measurement of low-income patients. Hospitals generally do not collect data on the income

of the patients they serve. Instead, a substitute (proxy) measure is needed to estimate the volume of low-income patients. Ideally, this proxy measure would correlate highly with patient income and therefore could be used to analyze the relationship between Medicare cost per case and service to a disproportionate share of low-income patients.

After extensive study, the Commission has recommended a proxy measure for all low-income patients. This proxy is based on the proportion of Medicaid patients per hospital under age 65, adjusted for variations in the extent of coverage of the low-income population of a state's Medicaid program, and an estimate of low-income elderly patients whose medical care is financed by both Medicaid and Medicare. There appears to be no empirical support for including the proportion of any other measure of Medicare volume in the definition of disproportionate share.

Based on the Commission's analytic efforts and those of others in the technical work group, the Commission found that there is a consistent, positive, and statistically significant relationship between the proportion of low-income patients and Medicare costs per case in urban hospitals.

July Recommendation

Consequently, the Commission recommended at its recent meeting a disproportionate share adjustment which has several components. The Commission believes that the adjustment should be paid to that subset of urban hospitals which is shown through analysis to have higher Medicare costs resulting from service to a high percentage of low income patients. As I noted before, the Commission believes that low-income hospital volume should be measured by a proxy which reflects both Medicaid and Medicaid/Medicare patient volume. This adjustment should be budget neutral -- that is, the dollars allowed in the adjustment should not be added to the prospective payment system, but rather should be redistributed from within the total. A threshold should be used in determining which hospitals will receive a disproportionate share adjustment so that the adjustment is targeted to those hospitals where there is a significant impact. For example, below a minimum volume of low-income patients, the hospital would receive no adjustment and above that minimum threshold the hospital would receive a gradually increasing adjustment up to a maximum.

We believe that following the recommendation I have outlined will result in a manageable, sound and equitable adjustment for hospitals which serve a high volume of low-income patients. At the Commission's direction, staff will continue its work on

refinements to the adjustment already suggested. The Commission and its staff would be pleased to continue to work with you or others interested in the problems faced by these hospitals. In addition, we will closely monitor any adjustment enacted and implemented.

Mr. Chairman, I appreciate this opportunity to testify before you as the Prospective Payment Assessment Commission begins work on its second full annual cycle. As I have mentioned, this subject is one on which Commissioners have shared unanimous views. It is one which we believe has extremely important equity considerations within the new prospective payment system. We are pleased that you are addressing the subject in this hearing and are ready to work with you and your staff in whatever way we may be of assistance. We would be pleased to answer any questions you or members of the Committee may have.

Senator DURENBERGER. You've heard my previous questions about cost transfer and the reponses.

Dr. ALTMAN. Yes, sir.

Senator DURENBERGER. What's your view on the degree or the extent to which hospitals with high proportions of uncompensated care might be transferring some costs to Medicare or to other payers, for that matter?

Dr. ALTMAN. Well, I've had occasion in my life to play with the Medicare cost stepdown system which was designed not by man or beast but by some strange monster. Let me say a couple of things about that. It's possible that hospitals in their own survival instincts would try to figure out ways to shift costs to people that pay the bills and away from people that don't pay the bills. It seems like a reasonable thing for an institution to do.

It turns out not to be as easy as theoretically we might think. I once played around with it; not for a real hospital, but just to see if I could understand how the system worked. And it is possible, but it isn't so easy. And, to the extent that it has been going on for a long time, it is not legal under the Medicare Program. Reasons other than shifting costs are much more compelling arguments for those higher costs. So, while theoretically I can't argue that it might not happen, it isn't so easy to do. It has been part of the program for a long time to the extent that it has already been done. Finally, without giving a numerical account, I don't think it adds up to major dollars.

Senator DURENBERGER. You want to go back over again your cross-State adjustment? Carolyne gave us a couple of examples of what that does in Texas and what it does in Massachusetts.

Dr. ALTMAN. Well, appropriately, she took the highest State in terms of the percentage of the poor that is covered by Medicaid, which I am pleased to find out is Massachusetts, and she took the lowest State, which unfortunately happens to be the State of Texas. Now it is true that if you just simply adjust using the formula, which sort of adjusts in reverse of the Medicaid proportion, you are going to give Texas hospitals a financial shot in the arm, and you are going to drain some dollars out of Massachusetts.

However, if you use the threshold, you will eliminate all hospitals in Texas and in any other States that are treating a small percentage of the Medicaid population. That's why I think the threshold is very important. As a matter of fact, in order for the threshold to kick in——

Senator DURENBERGER. This is what I missed in your testimony.

Dr. ALTMAN. When you look at the Medicaid plus Medicare crossover, in order for the adjustment to begin, the hospital has to have at least, say, 15 percent of its total patient days from Medicaid. And so until you get to 15 percent of the days that are paid by Medicaid, plus the crossovers, the hospital gets no adjustment at all. And that will eliminate a substantial number, if not all, of the hospitals that are in, say, low Medicaid coverage areas and maybe have 2- or 3-percent Medicaid days that would wind up getting that kicker that Dr. Davis talked about.

Similarly, in Massachusetts or other States with high-Medicaid coverage, where you do have high concentrations, sure they would have a lower adjustment, but they would see the benefit of serving a large percentage of Medicaid patients.

So I was particularly concerned about the same issue she brought up. And the staff convinced me by the analytic work that the problem is not what she points out.

Senator DURENBERGER. The data on which the DRG is based included higher costs we used to pay for disproportionate share hospitals when we were running at cost-based reimbursement.

Dr. ALTMAN. Yes.

Senator DURENBERGER. And it seems like a lot of these institutions don't do well under any kind of limit, whether it's the old 223 limits or a PPS limitation. Can we assume that the only problem of the poor elderly is severity and locational issues? Isn't there just some lousy management that attributes to some of these problems?

Dr. ALTMAN. As the hospital industry knows, I do occasionally criticize. The industry would never defend every administrator. So far be it from me to say that part of the problems are not due to administrative problems. But it's hard to understand why it's so concentrated in those hospitals that we ask to take on the extra burdens of caring for that part of society that doesn't pay its bills. And if poor management is the case, then it calls into question why that has happened. Is it because of—and I'm not saying it is—is it because of the location of those hospitals; that is, in fact, it's more difficult to get the staff there?

I've had to deal recently with the people who run Boston City Hospital. I know another hospital which I serve as a member of the

board, and which has a high proportion of Medicaid patients. I would defend the quality of their administrative capacity. I think they just have a tougher problem. And you are right. Any formula that tries to play a neutral position with repect to the toughness of running an inner city, large hospital with 30 to 40 percent Medicaid-Medicare, crossover, and bad debt, is understating the problem of running that kind of institution.

Senator DURENBERGER. This will be my last question. The staff here knows, because I talk about it every once in a while, that one of the things that bothers me most, and I thought about it when John Heinz was using Cook County as an example—and I seem to debate more with people from Cook County than anybody else, but they must go to more conferences than anybody—but what I usually do when I get into an argument with the staff is I hold up a piece of paper like this and I say, now, this is a locational decision or this is location as we use it. Everybody living within this set of ZIP codes or this block or this natural neighborhood or whatever it is used to getting their care here. The reality is that in lots of large cities in this country—mine is no exception, and it's not that big, Minneapolis and St. Paul—they are all there. The big old ones and some of the newer big ones and so forth. And I assume they are all having wage problems; they are all having the security problems; they are all having this; they are all having the that. So something is bothering me about how we go about making these decisions about, you know, picking the hospital, because you could go on an historical basis into that area where Cook County Hospital is, in Chicago, and you will find that, all the poor are going to that hospital. But if you look around that area of the city, there are several other very large private hospitals, which may not be taking that many poor. And you may find that example in other communities.

I'm wondering the degree to which location is a proxy for the reimbursement system or location becomes some kind of a proxy for deciding that you are eligible.

Dr. ALTMAN. That's a good point. I have a similar sense, as you do, that there is a heavy concentration of many of the best hospitals in this country surrounding many of our public hospitals. New York and Boston surely would have this situation.

And if we look at the kind of adjustments that you have already made in the PPS system and those that are being proposed, you find that they focus on many of the same hospitals. So that whether you are dealing with teaching adjustments, with severity or wage adjustments or disproportionate share—now they fall differentially on hospitals, though you might have private hospitals, nonprofit, that gets a heavy kicker for the teaching adjustment. And then another one would get a kicker for charity care. And a third one was looking for a disproportionate share adjustment.

There is no question that they do share common attributes for location. But they don't share other attributes. And when you listen, I am sure, to the next panel, Jim Morgan can tell you chapter and verse about the problems he has in running a public hospital; problems that his compatriots who are also in urban areas don't have when they have very small disproportionate share populations.

So, yes, location does not explain it all. Now there are, in converse, some hospitals that treat a disproportionate share of low income that are not in those inner city rings that may have the problems.

But it is interesting, as Carolyne pointed out, no matter how the statistics were run and they were run many different ways—when you break them down in terms of urban and rural, or small or large size, the overwhelming proportion of the dollars and the issue is large, urban hospitals.

Senator DURENBERGER. It seems to me HCFA is recommending we have in their interim rules an application process. The hospital has to apply for PPS or DSH status. Am I correct in that?

Dr. ALTMAN. Well, I think it's inconsistent with the basic structure of the PPS system. I can see the need for some exceptions and for appeals on the part of the administrators. But when you isolate a consistent problem that spreads throughout the whole system, and in a situation where you can develop a formula, the solution should be systematic. It just seems so inconsistent with the structure of the PPS/DRG system that I don't think it's correct to make the hospitals apply for disproportionate share adjustments.

The problem is seen in too many hospitals, and it's too consistent. And that's not what you use an exceptions process for.

Senator DURENBERGER. All right. Thank you very much.

Dr. ALTMAN. Well, thank you, Mr. Chairman.

Senator DURENBERGER. Now, finally, a panel consisting of Jack Owen, executive director, American Hospital Association; Dr. James Bentley, associate director of the department of teaching hospitals, Association of American Medical Colleges; and Dr. James Mongan, executive director, Truman Medical Center, Kansas City, KS, on behalf of the National Association of Public Hospitals, with his sidekick, Larry Gage.

Gentlemen, I appreciate very much you being here. We don't give you quite as much time as we gave the researchers, recommendors, whatever we call them. We are going to give you the usual Bob Packwood 5 minutes. If you happen to run over, I probably will not reach out and beat up on you. So we will use the lights as a guide for your testimony. Your full statements will be made part of the record. And, in particular, I guess, I don't want to hold you strictly because you may have thought of a summary of those statements, but some of the questions that have already been asked and some of the responses thereto, you may want to incorporate into your responses in your opening statements. So I don't want to restrict you too strictly to the 5 minutes.

We will proceed with Jack Owen.

STATEMENT OF JACK OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC

Mr. OWEN. Thank you, Mr. Chairman. I appreciate this opportunity to testify on the Medicare prospective pricing issue that's critical to the availability, the accessibility, and quality of needed community health services.

As spokeman for 6,100 member hospitals, we view this provision of an adjustment as a matter of equity. And I would start off by

saying that we have no disagreement at all with the three points that you started out with, and would agree with them as well. We are not looking at this as an answer to save hospitals. We are not looking at this as an answer to save the indigent population in the country. That's a matter for another committee and another time. But we do believe there is an issue of equity, and it has certainly been explained by the previous panel, both CBO and PROPAC. So I'm not going to go back into that. My testimony has been submitted to you.

But the question is not whether there should be an adjustment, but how. Because the need is well documented by everyone who has spoken, and we think the time is right to do something about it, and we applaud the House for what they did—not that it was so perfect, but at least they moved forward. And we hope the Senate will move forward in the same fashion.

We know that there are a lot of reasons why disproportionate share hospitals have higher costs. Low-income beneficiaries tend to present more complicated conditions on admission to hospitals, have home conditions, face nursing home admitting restrictions, and require longer inpatient stays. Inner city hospitals compared with urban hospitals outside the city core pay wage differentials and have other factors. So we know that those are all there.

But we have been frustrated over the HHS failure to implement any disproportionate share provision in the law to date. It's always, "we will study it a little more," and "we will come back next year." And we think the time for study has passed, and that there should be a movement forward to provide some kind of adjustment for these hospitals.

We would like to see rural hospitals as well as urban hospitals be considered. If the principle is correct, then we ought to apply across the board. I understand there is difficulty with that, and part of it, I suspect, is that the rural hospitals do not have as much sophisticated equipment as the larger teaching hospitals. And, therefore, they don't get the patients that are as intense. Those are Medicare patients I am talking about. And they usually go to an inner city or a teaching hospital. And that's part of the reason why we don't see that difference between the cost for caring for a Medicare patient in a rural hospital that has a high number of nonpaying Medicaid or charity care.

We feel that Medicaid and non-Medicaid should both be covered by the proxy because there are some problems with just using Medicaid, and they have been discussed briefly with you. But the feeling is that, for those States that have low Medicaid eligibility requirements, patients may not come in as Medicaid patients; therefore, they are not considered as part of the charity load that that hospital takes care of, and there ought to be some way when there is a case like that for the hospital to have an opportunity to participate.

I think the House tried to attack the problem by putting a 30-percent threshold of non-Medicaid patients. And if we looked at the statistics of the hospitals that we saw, we found that most of those hospitals that fell into that category were from the South and the largest number of any State was Texas.

There are not, however, a lot of hospitals that fall into that category because most of them get picked up in the threshold of 15 percent at Medicaid, and there were only some 39 hospitals altogether.

But we would like to see a proxy that captures the full extent of the medical resources provided to indigent patients and provide it both to rural and urban hospitals.

We also recognize the need for a sunset—to examine the shortcomings, in accounting for severity of illness, and to meet some of the inadequacies in the labor market definitions and what have you. And so we have no problem with sunsetting it because we know you are starting out on a new track and you may not have the right approach. Probably you won't pay nearly as much as is needed. But in any event, it's a chance to look at it and come back to it.

I would say that—and I can tell you that we have cooperated in the past—the American Hospital Association will work closely with your committee and staff to see what kind of information you need that we have. We have worked with CBO and with PROPAC and with the House. We will continue to work that way to see if this problem can't be rectified, and that we move forward, and in concept recognize the problem that those hospitals that take care of a disproportionate share get their fair equity in their Medicare prices. Thank you.

Senator DURENBERGER. Thank you very much.

[The prepared written statement of Mr. Owen follows:]

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON FINANCE OF THE UNITED STATES SENATE ON PROVISION OF A SPECIAL ADJUSTMENT TO MEDICARE PRICES FOR HOSPITALS SERVING DISPROPORTIONATELY LARGE NUMBERS OF LOW-INCOME OR MEDICARE PATIENTS

July 29, 1985

SUMMARY

The American Hospital Association (AHA), concerned that the Department of Health and Human Services (HHS) has failed to implement a Medicare adjustment for hospitals with disproportionate numbers of low-income or Medicare patients, urges Congress to stipulate an adjustment through legislation. Such an adjustment, justified by studies completed by the Prospective Payment Assessment Commission (ProPAC) and other organizations, would recognize that hospitals with high volumes of low-income patients have higher Medicare costs-per-case than other hospitals. Several approaches have been suggested; the AHA views a measure of Medicaid revenue plus uncompensated care as a percent of gross patient revenue as the most feasible. Such a measure, with verification of data by Medicare fiscal intermediaries, would overcome the serious limitations of Medicaid-based definitions employing either admissions or patient days criteria in capturing the full extent of medical resources committed to low-income patient care. During the period of implementation and assessment of the provision, there could be study of related problems, such as the DRG system's shortcomings in accounting for severity of illness and the need for more realistic labor market definitions of the area wage index.

INTRODUCTION

Mr. Chairman, I am Jack W. Owen, executive vice president of the American Hospital Association, which represents more than 6,100 member hospitals and health care institutions and approximately 38,000 personal members. I am pleased to be here to address the need for implementation of an adjustment to Medicare prices for hospitals that serve disproportionately large numbers of low-income or Medicare patients.

In the AHA's view, provision of an adjustment to "disproportionate-share hospitals" is a matter of equity. As the Medicare prospective pricing system has evolved, equity of payment to hospitals has been, and remains, a major issue. Not only is payment equity important to hospitals' sense of fair treatment under prospective pricing, but it also is critical to the availability, accessibility, and quality of needed community health services.

According to the design of the prospective pricing authorizing legislation, Medicare payments to hospitals vary across the country, with the variance due to a hospital's mix of patients, as categorized by diagnosis-related groups (DRGs); a hospital's area wage level; and a hospital's location, by metropolitan statistical area (MSA) or non-MSA; as well as the system's phase-in schedule toward national prices and its price adjustments to recognize hospitals' specialized roles and circumstances. In terms of price adjustments, special treatment is permitted rural referral centers, cancer treatment centers, sole community providers, hospitals in MSAs that span

regions, facilities redesignated from urban to rural, and--as stated--hospitals serving disproportionately large numbers of low-income or Medicare patients.

Although HHS has recognized and implemented other warranted adjustments, it has failed to exercise authority regarding provision of a "disproportionate-share adjustment," despite the fact that the HHS Secretary was directed to implement one by both the Social Security Amendments of 1983 and the Deficit Reduction Act of 1984. As hospitals enter the third year of the prospective pricing system, the Secretary, under court order, has issued only a vaguely specified appeals procedure for self-defined "disproportionate-share providers."

NEED FOR AN ADJUSTMENT

The need for an adjustment for hospitals serving disproportionately large numbers of low-income or Medicare patients is well documented. ProPAC, after reviewing studies by the Congressional Budget Office (CBO), HHS' Health Care Financing Administration (HCFA), and the AHA, concluded--in an April 1, 1985 report to the Secretary--that it "is convinced that hospitals serving a high volume of low-income patients (as measured by a variety of definitions) do incur higher Medicare costs per case. ...The precise reasons for these higher costs are unknown. Based on its studies, however, the Commission is also convinced that these higher costs per case are substantially due to factors beyond the control of these hospitals."

In its report, ProPAC formally recommended that the Secretary develop and implement a disproportionate-share adjustment for Fiscal Year 1986.

ProPAC based its decision upon various factors. Low-income beneficiaries tend to present more complicated conditions upon admission to hospitals, due to often-neglected medical problems and multiple diagnoses. Because of home conditions or nursing home admitting restrictions, they tend to require longer inpatient stays, as well as more ancillary, nursing, and special services, than other patients. It is widely acknowledged that the present DRG system does not adequately recognize either severity of illness or social factors.

Moreover, inner-city hospitals, compared with urban hospitals outside the city "core," may have to pay wage differentials to attract and retain employees; however, the present area wage index boundaries assume that all hospitals within an MSA compete equally for labor. In addition, disproportionate-share hospitals may have special costs, for social work, translator services, nutritional programs, and "stand-by" staff, as well as certain expenses associated with such tertiary services as burn care, trauma centers, and neonatal intensive-care units.

For all these reasons, an adjustment clearly is needed.

LACK OF ACTION BY HHS

For three years, the AHA has asked HHS to implement the adjustment called for by statute to recognize the special needs of hospitals treating

disproportionately large numbers of low-income patients. HHS, in its June 10, 1985, notice of proposed rulemaking on FY 1986 Medicare payments, indicated that it rejects ProPAC's and CBO's analytic work, as well as other statistical studies, because the population of hospitals considered in the studies is not "representative." The completed studies have, however, consistently shown a relationship between the percentage of a hospital's patients that are low-income and the hospital's Medicare costs per case. Moreover, the relationship detected by these studies is generally of the same order of magnitude.

In the notice, HHS states that its own studies also show a significant relationship between the low-income percentage and Medicare costs per case, although these studies have never been made available for public scrutiny. However, in a July 1, 1985, regulation issued under court order in Redbud Hospital District v. Heckler, the Secretary contended that "...current data do not show that an adjustment is warranted."

Despite the economic evidence and ProPAC recommendations, HHS has thus far declined to implement an adjustment factor for disproportionate-share hospitals. The only HHS policy action has been to create, under court pressure, a vaguely specified appeals procedure. This procedure, even if administered in good faith, would require fiscally stressed hospitals, using their own definitions, to prepare extensive and costly applications with highly uncertain prospects for approval.

HHS' intent to delay the development and implementation of an adjustment factor pending further study is totally unwarranted. According to the notice, HHS will wait for the development of a totally satisfactory data base before proceeding with the development of an adjustment factor, which is dependent upon HCFA's confirming the existence of a significant relationship between the low-income percentage and Medicare costs per case and identifying the reasons for any such difference. This level of statistical scrutiny is reflected in no other aspect of the prospective pricing system. Policymakers invariably must accommodate some degree of data incompleteness and imperfection in making real-world decisions. All evidence indicates that disproportionate-share hospitals are at unfair risk under prospective pricing as presently designed. Nonetheless, HCFA seems to be waiting indefinitely for perfect data on a real and growing problem that Congress empowered HCFA to correct at the outset of prospective pricing. In ignoring the instructions of Congress, the recommendation of ProPAC, and the advice of various organizations, HHS is failing to meet the needs of both Medicare beneficiaries and providers.

The immediate issue at this point is not whether or when to implement an adjustment, but how to do it. In considering short-run implementation issues, one should of course not lose sight of fundamental, long-term issues, including the need for more realistic direct and indirect severity adjustments and more accurate hospital labor-market boundaries. The key implementation issues to be addressed include measurement of low-income patient volume, urban/rural distinctions, and payment determination methods.

IMPLEMENTATION ISSUES

Measuring Low-Income Patient Volume

This topic has been the focus of much discussion by congressional staff, ProPAC, CBO, the AHA, and other interested parties. It has generated various proposals, each with its own strengths and weaknesses. The proposals fall into two main groups--those that are "Medicaid only" and those that include both Medicaid and the non-Medicaid poor. Examples of measures that are fundamentally "Medicaid-only" include the following:

- A hospital's percent of Medicaid discharges or patient days adjusted for state Medicaid program strength.

- The percentage of a hospital's patient days represented by Medicaid Aid for Families with Dependent Children (AFDC) recipients plus Medicaid patients eligible for Part B Medicare benefits.

There are several problems with "Medicaid-only" definitions:

- Omission of large categories of low-income patients (e.g., childless couples and the uninsured working poor).

- Unfairness to hospitals heavily committed to serving the poor that are excluded from Medicaid. (AHA analyses indicate that over 300

hospitals have below-average Medicaid percentages but above-average uncompensated care levels. Over 340 hospitals are providing at least 10 percent more low-income patient services than indicated by Medicaid percentages only. These 340 hospitals represent 35 percent of total uncompensated care provided by community hospitals nationally. Special provisions for public general hospitals only, while constructive, ignore the problems of private hospitals that serve high proportions of non-Medicaid poor. Because of this, Medicaid-based definitions would fail to allocate limited funds according to rational priority.)

- Inadequacy in times of economic recession. The most recent pattern has been for recessions to force cutbacks in state Medicaid programs despite an increase in need.

Other proposals include the non-Medicaid poor as well as Medicaid-eligibles. A measure that would capture the full extent of medical resources provided to indigent patients is Medicaid revenue plus uncompensated care as a percent of gross patient revenue. Such a measure would overcome the serious limitations of Medicaid-based definitions employing either admissions or patient days.

Two main objections have been raised to inclusion of uncompensated care, especially the use of charity care plus bad debt, as the best available measure:

- Self-reporting of the data by hospitals, although fiscal intermediaries presumably would be asked to verify data used in implementation.

- Variation in hospitals' accounting, collection, and patient classification practices. While true to some extent, this source of "error" is likely smaller than that of ignoring the full spectrum of hospital services to the non-Medicaid poor.

Recognizing Both Rural and Urban Hospitals

Because disproportionate-share studies fail to find the same type of results for rural as for urban hospitals, some policy proposals omit rural facilities. This approach is not well founded. To date, disproportionate-share studies have made use of the prospective pricing area wage index, which is based on the unrealistic assumption that all rural hospitals in a state compete in the same labor market. Consequently, statistical results for rural hospitals should be used very cautiously in developing policy.

Several policy options should be considered to ensure the quality and accessibility of care in rural areas, including:

- Application of urban disproportionate-share results to rural hospitals, with recognition of the potential hardships for those hospitals of the use of a Medicaid-based, low-income service measure;

- Refinement of labor market boundaries for both rural and urban areas;

- Expansion of the volume reduction offset policy from sole community providers to rural hospitals; and

- Recognition of the problems of hospitals with naturally unstable admissions and case mixes, although the payment system assumes these "average out" over each hospital's fiscal year.

Payment Approach

A formula method clearly seems preferable to a case-by-case administrative appeals approach, because it would be more objective, more consistent in application across hospitals, more immediate for affected hospitals, and less of an administrative burden.

A basic issue under a formula method is where to place a "cut-off": the minimum low-income patient percentage, however defined, that a hospital must have in order to qualify for an adjustment. This clearly depends on the economic relationship between Medicare costs per case versus low-income patient volume, as well as on the extent of available funds.

Priority should clearly go to hospitals most heavily involved in low-income patient care, and the low-income measure should be chosen accordingly.

AHA's Recommendation

Based on the weight of economic evidence, ProPAC recommendation, and the risks of further HHS delay, the AHA recommends that Congress:

- Mandate an adjustment for FY 1986;
- Avoid "low-income" measures that are essentially Medicaid-only and that therefore fail to capture the full extent of medical resources committed to low-income patient care;
- Adopt a "Medicaid plus uncompensated care" measure as the most practical, sensitive approach for the time being, with verification of data by Medicare fiscal intermediaries;
- Cover rural hospitals the same as urban, and consider other special provisions for rural hospitals under prospective pricing; and
- Provide for an explicit period of continued study of unresolved prospective pricing issues.

A year's pause at the 50/50 blend of respective hospital-specific and federal rates would provide a significant opportunity for the review and correction of fundamental design problems in the prospective pricing system. These problems include the DRG system's shortcomings in accounting for the severity of cases;

the need for more realistic labor-market definitions for the area wage index; the present payment system's bias against certain categories of hospitals (e.g., larger hospitals, urban hospitals); and the special problems of rural hospitals under prospective pricing.

CONCLUSION

The AHA appreciates this opportunity to present its views on the need for a Medicare adjustment for hospitals with disproportionately large numbers of low-income or Medicare patients and the formula to be used in providing such an adjustment. Provision of an adjustment--long delayed by HHS--is an equity issue that is critical to the availability, accessibility, and quality of needed community health services. For this reason, the AHA has asked 1,248 hospitals that--according to AHA 1983 Annual Survey data are above average in percentage of Medicaid, bad debt, and charity care gross patient revenues--to agree to release information to Congress relating to the disproportionate-share issue. The AHA also has cooperated with Congress, ProPac, CBO, and other organizations in seeking a definition of "disproportionate share" and in working out a formula for an adjustment. The Association is committed to working with this Subcommittee to gain enactment of an adjustment during this congressional session.

STATEMENT OF DR. JAMES BENTLEY, ASSOCIATE DIRECTOR, DEPARTMENT OF TEACHING HOSPITALS, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, WASHINGTON, DC

Senator DURENBERGER. Dr. Bentley.

Dr. BENTLEY. Thank you very much, Mr. Chairman. I would like to note that I believe this hearing marks something of a milestone. I haven't heard a lot of strident arguments from anyone today about whether prospective payment is feasible or can work. Rather, I've heard a concern about equity. And in that sense, as I have listened to this issue debated across town for the last year, the testimony has much more of the flavor of a tax proposal: one person's equity is another group's special advantage or disadvantage. I think that's the kind of language we are going to hear as prospective payment advances.

Looking at the "disproportionate" share adjustment, the AAMC believes that this is an important adjustment in an average price system. I would underline, from a less analytical point of view or less statistical point of view, the word "disproportionate." It does not strike me as surprising that everyone who has looked as the data finds a need to have an initial threshold. While there are a variety of statistical reasons for doing that, the whole concept is that if the workload for these patients was spread equally, then an average price system would be adequate. It's the fact that the distribution is inequitable or maldistributed that leads to the need to look at a threshold in the statistical finding.

Second, the AAMC believes that this issue of disproportional share Medicare patients can be addressed without addressing the larger, equally important issue, of charity care. We don't believe you have to wait. If we had waited for the perfection the administration seems now so clearly to relish, we would never have started prospective payment in the first place.

As the disproportional share adjusment is looked at, we believe there are three questions of a policy nature that need to be examined: First, how shall the concept of disproportional share be defined to identify hospitals? There have been two competing approaches, one based on revenue measures. For example, the proportion of bad debts or charity care or Medicare patients is expressed in gross charges. The second has been patient volume measures, the number of patient days of a given kind of patient.

The AAMC would prefer the patient volume measures, be they patient days or admissions. We would recommend using the empirical results from CBO, from PROPAC and other groups to pick the particular measure based on its characteristics in identifying atypical costs.

The second question: What kind of an adjustment should be provided? I would have to say, based on the history of section 223 limits, we don't think the exception experience was adequate. It continually functioned like a magic act. Those who got an adjustment never were sure why they got one. Those who didn't get an adjustment never were sure why they didn't get one. And in any case, a hospital's ability to document the numerator without public data on what the denominator was, left many of our members with the sense that the exception process was not administratively fair.

There then becomes at least two options. One would be to do a passthrough for specific costs that the numbers of this committee, or that the analytical groups, would identify as being atypical—perhaps security costs, social work costs, et cetera. An alternative approach is the kind of statistical adjustment we have heard about up to this point in the hearing.

The AAMC has no strong point of view on which of those two is the best approach. We would note that in the teaching hospitals there is a passthrough for direct medical education, and a statistical adjustment for the indirect costs accompanying medical education. Thus, we find that it has been possible to use either or both approaches. We would, however, caution that we are starting with poor data; we are starting with somewhat dated data. And just as you are revisiting the adjustments in the medical education are, we suspect that there will be a need for continued oversight of the disproportional share adjustment, whichever approach is taken.

The third question: Where does the money come from to fund the adjustment? We recognize that the resident-to-bed adjustment and the way in which it was constructed provide that current adjustment, as explained by Dr. Altman, is absorbing some of the cost of disproportional share. Thus, we would expect that is a disproportional share adjustment is made, there would be some recomputation of the resident-to-bed adjustment, presumably lower.

However, we also recognize that this is an average price system, and that in the system to date, hospitals without disproportional share patient loads have been relatively overpaid to those who have a heavy disproportional patient load. And we would expect, therefore, that the urban rate or the rural rate or both rates for all hospitals would have to be addressed and provide some of the funding in a budget-neutral sense.

I would conclude with one observation. As I have listened to the discussion across this town in the last year, it is clear to me that equity is in the eye of the beholder. One of the difficulties we have in equity issues is that it has been difficult for different groups or interests to judge solutions absent data or information.

I commend CBO on the kinds of tables and information they have released today. I would hope we could have more of that information publicly available from CBO, from HCFA, from PROPAC. I think, if we are going to address equity adjustments between categories of hospitals, sunshine is necessary. We need adequate release of analysis and data. Thank you.

Senator DURENBERGER. Thank you. And particularly for that last comment. I think you say what we always encourage people to develop up here. And they don't listen to us. They may not listen to you. But it's on the record, and it will enforce whatever efforts we put behind our requests also.

[The prepared written statement of Dr. Bentley follows:]

STATEMENT

OF THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

A "Disproportional Share Adjustment"
for the
Medicare Prospective Payment System

Presented to the Subcommittee on Health
Committee on Finance
U.S. Senate

by

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July 29, 1985

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Summary of Points

I. Prospective Payment: Explaining Hospital Differences

A. One patient and three hospital variables are the only differences that will be recognized in prospective payments.

B. The AAMC believes a key cause of the technical and policy problem confronting this Subcommittee is the use of too few variables in setting the price per case for hospitals.

II. Disproportionate Share Providers

A. The AAMC recommends that the higher costs of indigent Medicare patients is an appropriate expense for the Medicare Trust Fund and that Medicare payments for those costs can be addressed without solving the generic problem of financing indigent care.

B. Defining the Hospitals

1. The AAMC prefers using the patient volume approach over the revenue approach because it is less susceptible to manipulation and is easier to interpret.

2. The AAMC believes the choice between volume measures should be based upon empirical analysis showing which specific variable is more consistently related to above average costs per Medicare patient.

C. Determining the Payment

1. The AAMC opposes using an exceptions process to determine a hospital's payment for its disproportional share low income Medicare patients.

2. It is not clear whether the cost passthrough or statistical adjustment is preferable.

III. The Resident-to-Bed Adjustment

A. The resident-to-bed adjustment is a proxy measure to provide appropriate compensation for the added patient service costs borne by teaching hospitals.

B. The Association of American Medical Colleges supports recomputing the resident-to-bed adjustment using current hospital resident and bed data; up-to-date, corrected hospital case mix indices; corrected wage indices; and a regression equation which incorporates only variables used in determining hospital DRG payments.

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The Association of American Medical Colleges (AAMC) is pleased to have this opportunity to testify on the current policy debate on a "disproportional share adjustment" for Medicare's prospective payment system. The Association's Council of Teaching Hospital's (COTH) includes over 350 major teaching hospitals participating in the Medicare program. In 1982, the most recent year for which the Association has data, COTH hospitals cared for over 1,680,000 Medicare admissions. Thus, the Medicare prospective payment system has a major impact on our members.

I am James D. Bentley, Ph.D., Associate Director of the Department of Teaching Hospitals at the AAMC. I have been involved with the technical and policy issues surrounding prospective payment since the late 1970's:

- o in 1980, I coauthored Describing and Paying Hospitals: Developments in Patient Case Mix;
- o in 1981 and 1982, I directed technical reports on the ability of the DRG and disease staging methodologies to account for differences in the costs of 24 teaching hospitals;
- o in 1982, I served as an External Advisor to the HCFA Administrator's Prospective Payment Task Force; and
- o since January, 1984, I have served as a member of HCFA's Technical Advisory Panel on Prospective Payment Studies.

Thus, I have had considerable personal experience in the prospective payment system, and this experience has been from the perspectives of both the system

designer and the hospital expected to live under it. This morning, I would like to address three issues:

- o the factors used by prospective payment to account for differences in hospital costs;
- o some suggestions for assisting disproportional share providers; and
- o the relationship between the present resident-to-bed adjustment and a disproportional share adjustment.

Prospective Payment: Explaining Hospital Differences

For prospectively-determined payments under the Medicare system, payment amounts are calculated by adjusting an average price by variables representing expected differences in patients and in hospitals. For differences in patients, the Diagnosis Related Groups are the only variable used to vary payments. For differences in hospitals, the variables used are geographic location; community wage rate; and, as a proxy for a number of items, the resident-to-bed ratio.

The ability of these patients and hospital variables to recognize legitimate differences in hospital costs is not completely understood. Nevertheless, it must be understood that one patient and three hospital variables are the only differences that will be recognized in basic DRG payments after transition. All other differences in hospital and patient costs are ignored by year four. The differences ignored in prospective payment include hospital bed size, range of services offered, socioeconomic mix of patients, central city or suburban location, and input price differences other than wages. Past research has shown each of these variables account for real differences in hospital costs. Ignoring

these variables caused relatively minor problems when prices were based 75% on the hospital-specific price component because the hospital's historical costs reflected all of its differences from the "average" hospital. As we move forward in the transition, however, the hospital-specific price component decreases and the price paid does not recognize major differences in the costs of different hospitals.

Therefore, the AAMC believes a key cause of the technical and policy problem confronting this Subcommittee is the use of too few variables in setting the price per case for hospitals. As the hospital-specific price component disappears, the present system lacks adequate adjustments that would recognize legitimate differences in the costs of different hospitals. One of the needed adjustments is recognition of the costs of disproportionate share providers.

Disproportionate Share Providers

Hospitals serving a disproportionate share of the poor face two significant problems. First, within a DRG, low income patients tend to use more services than non-indigent patients. This often results from waiting longer to seek medical care, or because of chronic illnesses and complicating conditions, or from the absence of a suitable home environment to which the patient can be discharged. As a result, low income patients use larger, more comprehensive hospitals having the necessary resources to treat the more complicated patient. Thus, indigent Medicare patients tend to be more costly than non-indigent Medicare patients. Secondly, non-Medicare indigent patients who do not pay their bills must have the costs of their care subsidized by other patients, private philanthropy, or government payments. Some argue that Medicare should help underwrite the care of non-Medicare indigent, at least where the hospital has few paying patients.

The AAMC believes the two facets of the problems confronting disproportional share providers must be separately addressed. Congressional committees examining the disproportional share issue must determine whether they wish to amend the prospective payment system to incorporate: (1) the higher costs of indigent Medicare patients, or (2) a payment to hospitals to assist them in caring for indigent non-Medicare patients, or (3) both of the above.

THE AAMC RECOMMENDS THAT THE HIGHER COSTS OF INDIGENT MEDICARE PATIENTS IS AN APPROPRIATE EXPENSE FOR THE MEDICARE TRUST FUND AND THAT MEDICARE PAYMENTS FOR THOSE COSTS CAN BE ADDRESSED WITHOUT SOLVING THE GENERIC PROBLEM OF FINANCING INDIGENT CARE.

To develop an adjustment for disproportional share providers, two steps are necessary. First, it is necessary to develop a definition of hospitals qualifying for the designation. Secondly, it is necessary to specify the type and amount of the adjustment to be paid to qualifying hospitals.

Defining the Hospitals

Two major approaches have generally been used in efforts to identify disproportionate share providers. The first compares revenue ratios. For example, the ratio of bad debt and charity care charges to total charges might be used to categorize hospitals. The second approach, compares patient volumes, in days or admissions, across hospitals. For example the proportion of Medicaid patient days to total days might be used to categorize hospitals. While either approach can be used,

THE AAMC PREFERS USING THE PATIENT VOLUME APPROACH OVER THE REVENUE APPROACH BECAUSE IT IS LESS SUSCEPTIBLE TO MANIPULATION AND IS EASIER TO INTERPRET.

The number of Medicaid patients and the number of Medicare patients with Medicaid eligibility could be used, separately or together, to identify disproportional share hospitals.

THE AAMC BELIEVES THE CHOICE BETWEEN THESE VOLUME MEASURES SHOULD BE BASED UPON EMPIRICAL ANALYSIS SHOWING WHICH SPECIFIC VARIABLE IS MORE CONSISTENTLY RELATED TO ABOVE AVERAGE COSTS PER MEDICARE PATIENT.

Determining the Payment

There are at least three approaches to establishing the amount of the payment for a qualifying disproportional share provider. First, an exception process could be employed in which the qualifying hospital identifies its atypical costs. Past experience with the exceptions process for Section 223 limits demonstrates the weaknesses of an exceptions approach. Under the 223 exceptions process, HCFA: (1) never established acceptable procedures for documenting an exception, (2) never published the data necessary to document an exception, and (3) never established public decision criteria for granting an exception. As a result of the Section 223 experience,

THE AAMC OPPOSES USING AN EXCEPTIONS PROCESS TO DETERMINE A HOSPITAL'S PAYMENT FOR ITS DISPROPORTIONAL SHARE LOW INCOME MEDICARE PATIENTS.

A second payment approach would use cost reimbursement to pay those specific expenses which are more prevalent in disproportional share hospitals. For example, a cost reimbursement passthrough could be established for personnel working in security, social work, and translator services. This approach has the advantage of targeting the extra funding to specific expenses. As a result, the hospital can use its DRG payment for atypical nursing, housekeeping and food

service costs, as well as for the longer length of stay of these patients. The disadvantage of the approach is that Medicare has no certainty how the hospital will use the funds freed up by the passthrough.

A third approach uses an observed statistical relationship between the variable used to define disproportional share hospitals and observed variation in hospital costs. For example, the ratio of a hospital's Medicaid patients could be related to a percentage increase in its payments. This approach is less difficult to implement than a cost passthrough; however, because it uses a statistical relationship to quantify a payment amount, some individual hospitals may be perceived as overpaid while others may still be perceived as underpaid.

It is not clear whether the cost passthrough or statistical relationship is preferable. Under the current system, direct medical education costs are paid using a cost passthrough and the resident-to-bed adjustment is based upon an observed statistical relationship. This Subcommittee and its staff have been reconsidering and proposing revisions in both teaching hospital payments. This suggests that Congress must continue to provide oversight and re-evaluate any particular adjustment.

The Resident-to-Bed Adjustment

When prospective payment was being considered, the Congressional Budget Office compared the system's impact on teaching and non-teaching hospitals. CBO found 71% of teaching hospitals would lose money compared with TEFRA, while only 32% of non-teaching hospitals would lose money. It should be noted that this impact assessment assumed the original or single resident-to-bed adjustment.

Why would teaching hospitals do so poorly? Four factors contributed heavily to this adverse impact:

- o First, when HCFA set the regional and national average prices, they computed the average on a hospital-weighted, rather than a case weighted, basis. Therefore, in computing the average, a major teaching hospital admitting 10,000 Medicare cases had the same impact as a small suburban hospital with 750 Medicare admissions. The effect of the use of a hospital-weighted average is that the "price norm" (i.e. average price) for urban hospitals is a 255 bed hospital. In the Council of Teaching Hospitals, the average hospital has 562 beds. The scope of services and therefore the average costs of a hospital generally vary with bed size. This was recognized in the TEFRA limits where hospitals were compared using bed size groups. HCFA's use of an approach that sets prices approximating the costs of a 255 bed hospital hurt teaching hospitals.

- o Secondly, the DRGs have only 468 categories for recognizing differences between patients. If each hospital received an equal variety of patients in each DRG, 468 categories would not cause serious problems. Teaching hospitals do not receive a random mix of patients. Teaching hospitals receive the sickest, most difficult and most costly cases. Without such an adjustment, teaching hospitals are hurt by an average pricing system. Unfortunately, no easily implemented

system to adjust the DRG for the difference in severity was available in 1983 and none is yet available.

- Third, hospitals in large metropolitan areas have higher average costs than those in smaller cities, and central city hospitals have higher average costs than suburban hospitals. These costs include differences such as increased security and social services departments. Teaching hospitals are heavily concentrated in the central cities of major metropolitan areas. Because the prospective payment system does not adjust for the higher costs of central cities, teaching hospitals are hurt by the average pricing system of prospective payment.

- Finally, when HCFA estimated the factor for the resident-to-bed adjustment, they included two variables in the analysis -- hospital bed size and urban area size -- which were not included in the payment system. As a result, the computed adjustment was understated and teaching hospitals were adversely impacted until Congress doubled the computed adjustment.

Thus, while the resident-to-bed adjustment is called the "indirect adjustment for cost accompanying medical education," it is, in fact, a proxy measure to provide appropriate compensation for the added patient service costs borne by teaching hospitals. Thus it helps correct for the fact that too few variables are used to set prices in the current system. Nevertheless, its "medical education" label permits the adjustment to be viewed as an educational payment rather than a correction for statistically consistent differences in cost between teaching and non-teaching hospitals. The AAMC is concerned about this misconception.

The resident-to-bed adjustment is a crucial equity factor in prospective payment. It should be retained, but it should be properly estimated. An unbiased and more defensible adjustsment can be obtained if the adjustment is re-estimated with an equation based only on the factors used in determining DRG prices and with up-to-date, accurate data. Therefore,

THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES SUPPORTS RECOMPUTING THE RESIDENT-TO-BED ADJUSTMENT USING CURRENT HOSPITAL RESIDENT AND BED DATA; UP-TO-DATE, CORRECTED HOSPITAL CASE MIX INDICES; CORRECTED WAGE INDICES; AND A REGRESSION EQUATION WHICH INCORPORATES ONLY VARIABLES USED IN DETERMINING HOSPITAL DRG PAYMENTS.

Some analysts have hypothesized that the resident-to-bed calculation may provide some adjustment for the greater expense of indigent Medicare patients in teaching hospitals; however medical education activity is not always a good estimator of the cost burden of indigent patients. Some teaching hospitals care for a disproportional number of indigent patients; others do not. In this circumstance, a separate indigent care adjustment should be established to acknowledge the cost impact of the more severely ill indigent patients.

The Association recognizes that the implementation of a disproportional share adjustment probably could result in some reduction in a properly computed resident-to-bed adjustment. We also recognize that if a disproportional share adjustment was implemented, some teaching hospitals would receive both the disproportional share and the resident-to-bed adjustment while others would receive only the resident-to bed adjustment. This is not unreasonable.

Conclusion

The AAMC supported the concept of prospective payment in 1983. Our members still favor a prospective system over an intrusive regulatory system. If the Medicare prospective payment system is to provide hospitals with an appropriate incentive for efficiency, methodological weaknesses must be eliminated, inaccurate data must be corrected, and real differences in the cost of various types of hospitals such as medical education, severity, and a disproportional share of Medicare indigents should be recognized. The AAMC recommendations have been developed to provide a more reasonable and equitable prospective payment

Senator DURENBERGER. Dr. Mongan, I want to apologize to you because you probably understand why you were described as coming from Kansas City, KS. It is just that this committee has just had a tendency to keep putting Kansas City into Kansas rather than into Missouri. But it is Kansas City, MO. And you are obviously welcome, as you have been for all of the years that I have been a member of this committee. Your full statement will be made part of the record.

STATEMENT OF DR. JAMES MONGAN, EXECUTIVE DIRECTOR, TRUMAN MEDICAL CENTER, KANSAS CITY, MO, ON BEHALF OF THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS, WASHINGTON, DC

Dr. MONGAN. As I look at the Medicaid rates, we do a little better in Kansas so if you want to make that official. [Laughter.]

Mr. Chairman, I am Dr. Jim Mongan, executive director of the Truman Medical Center, the public hospital for Kansas City, MO. And I am here today representing the National Association of Public Hospitals.

As one who has served for 7 years as a member of the professional staff of this committee, I appreciate the opportunity to return to this room I know so well and speak now on behalf of those hospitals which serve our Nation's poor and disadvantaged elderly.

I would like to submit my full statement for the record, and just summarize its contents now.

Mr. Chairman, you know from prior testimony what public hospitals are and you know about the special role we play in our Nation's health care system by serving those who can't afford treatment anywhere else. My hospital is typical of public hospitals. Only 15 percent of our patients have private insurance. Twenty percent of our patients are covered by Medicare, and a full 80 percent of these are low-income elderly people. Twenty-five percent of our patients are nonelderly Medicaid recipients, and the remaining 40 percent have no coverage at all from public or private programs.

In addition to the dramatic problems we have on the revenue side, our costs are higher for all our patients, including our Medicare patients, as this chart illustrates, chart No. 4, in our handout. Because our patients are sicker, because they need extra health and supportive services, because we must maintain specialized services such as major trauma centers to serve our communities.

Mr. Chairman, this committee took a giant step forward when you moved us from cost reimbursement to prospective reimbursement. And the new system has had admirable results. But the new DRG system also has serious flaws, as illustrated on this chart, chart No. 1 in your packet. Among its major flaws is that it does not adequately take into account differences in severity of illness nor does it take into account the very real cost of treating a disproportionate share of the elderly poor.

Mr. Chairman, I assure you that these flaws are not technical quibbles. They are flaws with huge reimbursement implications, which have been masked in the first year of the program because only 25 percent of the payments were based on the deeply flawed regional and national rates.

However, if we continue to plunge on to a national rate, hundreds of millions of dollars will slosh from one region to another and millions of dollars from some hospitals in each of your States to other hospitals in each of your States. Not because they are more or less efficient, but because of the flaws in the national rate.

Now having described our concerns, I'd like to turn to recommendations for improving the system. Our first would be to freeeze the transition to a national rate until solutions are developed to its serious flaws. I've heard only one argument freezing the transition and that is that it would somehow emasculate the incentives for cost containment. Stated most simply, that's incorrect. It is after all the existence of a known prospective rate that gives administrators the incentive to control costs, and that incentive is not weakened whether the prospective rate is a national rate or an institutional-specific rate. Just look at the record. The enormous savings achieved in the last year were achieved in a year when 75 percent of the payment was institutional specific. And why people believe that the many hospitals which will receive unearned windfalls under a fully national rate will have more reason to be efficient alludes me.

So I would strongly urge you to freeze the transition until the DRG system can be improved.

My second recommendation is that this committee move now to deal with at least one of the major flaws in the DRG system. Its failure to recognize the very real cost of providing care to a disproportionate share of the poor elderly.

These higher costs are real, as shown on the next chart. There is now solid data from all the major parties involved—HCFA, the AHA and CBA—which not only show that these costs exists, but which also agree very closely on the extent of these additional costs. With this kind of agreement, there is simply no reason for a delay for passing an adjustment for disproportionate share of providers.

Mr. Chairman, there have been few recent developments on such an issue. The Secretary, under duress, issued regulations address-

ing this issue and the Ways and Means Committee approved a provision in this area.

Now in fairness to the Department, they were honest. They made it clear that they were forced to put forth this regulation and that they did not believe in it. In reviewing the regulation, it's clear that any adjustments are discretionary on the part of the secretary. It should be clear, given her honesty stated bias, that they will never be granted. So I would submit that this committee needs to act, if you believe a real adjustment should be made.

We believe that the Ways and Means Committee provision is very good legislation, and we would urge that you adopt something similar. Our only proposed modification would be to make certain that all disproportionate share providers are treated equally by adjusting for differences in State Medicaid programs.

Mr. Chairman, to summarize, I would urge the committee to take two actions: freeze the transition to a national rate, and legislate a specific disproportionate share adjustment. These two steps are critically important to our Nation's public hospitals whose special mission to the poor makes them at the same time our most valuable yet most vulnerable health care resources.

Thank you for the opportunity.

Senator DURENBERGER. Thank you very much.

[The prepared written statement of Dr. Mongan follows:]

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Denver General Hospital
Boston City Hospital
District of Columbia General Hospital
Harris County Hospital District (Houston)
University of Medicine and Dentistry of New Jersey University Hospital
Grady Memorial Hospital (Atlanta)
Cleveland Metropolitan General Hospital
Santa Clara Valley Medical Center (San Jose)
The Los Angeles County Hospitals
Parkland Memorial Hospital (Dallas)
Truman Medical Center (Kansas City)
San Francisco General Hospital
Bellevue Hospital Center
Bronx Municipal Hospital
Cook County Hospital
Contra Costa County Health Services Department
Brackenridge Hospital (Austin)
Wishard Memorial Hospital (Indianapolis)
Chope Community Hospital (San Mateo)
Worcester City Hospital
Alameda County Health Care Services Agency (Oakland)
Westchester County Medical Center
Milwaukee County Medical Complex
Nassau County Medical Center
Regional Medical Center of Memphis
Pacific Medical Center (Seattle)
University of New Mexico Hospital
Harborview Medical Center University of Wash. ton
Fresno County Valley Medical Center
General Hospital, Ventura County
R.E. Thomason General Hospital (El Paso)
Ham Medical Center (Bakersfield)
University of Cincinnati Hospital
University of Texas Medical Branch
Queens Hospital Center
Hurley Medical Center (Flint)
San Bernardino County Medical Center
San Joaquin General Hospital (Stockton)
Riverside General Hospital, University Medical Center
Oregon Health Sciences University Hospital
Spartanburg General Hospital (Spartanburg, SC)
Harlem Hospital Center
Charity Hospital of Louisiana
Maricopa Medical Center (Phoenix)
St. Louis County Hospital
Memorial Medical Center (Savannah, GA)
Amarillo Hospital District

STATEMENT OF JAMES MONGAN, M.D.
Executive Director
Truman Memorial Medical Center
Kansas City, Missouri

Subcommittee on Health
Committee on Finance
United State Senate
July 29, 1985

Mr. Chairman, members of the Subcommittee, I am James Mongan, Executive Director of Truman Medical Center, Kansas City, Missouri, a 608-bed public teaching hospital. I am particularly pleased, as a former staff member of this Committee, to be here today. I also serve as a member of the Board of Directors of the National Association of Public Hospitals, and I am accompanied this morning by Larry S. Gage, President and General Counsel of that organization. NAPH consists of 50 public hospitals and hospital systems that serve as major referral centers and hospitals of last resort for the poor in most of our Nation's largest metropolitan areas.

We welcome the opportunity to testify before the Subcommittee this morning, to discuss the implementation of the Medicare Prospective Payment

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System, as related to the situation of hospitals that serve a significantly disproportionate number of low income patients. In the interest of time, and because we have testified recently on the more general situation of public hospitals in America today, I will present my testimony this morning in outline form, with reference to several specific charts and tables which I have included at the end of my prepared statement.

I. Public Hospitals in Our Nation's Major Metropolitan Areas, and Other "Disproportionate Share" Hospitals, Are Already Being Adversely Affected by The PPS System.

A. The Administration's current budget proposal would reduce the projected Medicare revenues of Truman Medical Center by over $1 Million next year. In fact, the Administration proposal, combined with a move to the National rate, would actually slash our Medicare payments to a level 4% below what we are currently paid.

B. Most NAPH members are also major teaching hospitals, and thus have benefitted to a certain extent from the indirect medical education adjustments. However, CBO and other analysts have clearly found that, among major teaching hospitals, government-owned hospitals have significantly lower operating margin than private teaching hospitals and would be much more seriously affected by any major reduction in those payments.

C. Most analysts now agree that there are several deficiencies in the present PPS methodology that contribute to the serious inequities of the system for disproportionate share hospitals. Those include, among other factors, the inability of the PPS system by itself to adequately account for: (Chart 1)

1. Differences in severity of illness for patients in certain DRGs, including patients with multiple diagnoses or who require multiple procedures.

2. Differences in the costs incurred by hospitals in inner cities, as opposed to those in suburbs, including wage differentials and other factors.

3. Differences in case-mix among hospitals, particularly teaching hospitals.

4. Extraordinary circumstances experienced by hospitals during or after their PPS-base year, which may require appeals or exceptions.

5. The special situation and extra cost experienced by hospitals serving significantly disproportionate numbers of low-income patients.

D. The Congress in general, and the members of this Committee in particular, clearly understand these inequities, and you have attempted on several occasions to address these flaws in the PPS system. The mechanisms you have enacted include outright exemption of certain hospitals, the indirect and direct teaching adjustments, a general appeals mechanism, and a specific adjustment for "disproportionate share hospitals". Unfortunately, HHS has refused to permit appeals or exceptions in many of the areas spelled out by the Congress as requiring attention. With regard to disproportionate share hospitals, this

includes their refusal even to develop definitional criteria and identify hospitals meeting that criteria, as the Congress demanded last year. We believe you must now remedy this refusal by HHS to acknowledge and address PPS inequities. You can accomplish this: first, by slowing down the present rate of PPS implementation; second, by paying careful attention to the appeals process generally; and third, by enacting an explicit adjustment for disproportionate share hospitals.

II. All Major Participants Now Agree That Metropolitan Area Public Hospitals, and Other "Disproportionate Share" Hospitals, Have Higher Medicare Costs Per Case, in Direct Relation to their Proportion of Low-Income Patients.

A. (Chart 2) The Urban Institute has found that urban hospitals providing a high volume of care to the poor have higher costs per in-patient day, and are more likely to have a negative net operating margin, than low volume hospitals.

B. (Chart 3) Perhaps more significantly, AHA, CBO, the District of Columbia Hospital Association and internal HCFA studies all demonstrate that higher Medicare costs are directly related to serving low-income patients. Even though each of these organizations used somewhat different measures and criteria, their studies have come to almost identical conclusions

with regard to the relative proportion of the impact on Medicare costs.

C. It is also important to note, as ProPAC did in our April report, that regression analyses have been used to show that this impact is clearly separate from the impact of such factors as teaching status, bed size, wage differentials and urban or rural location. Only two weeks ago, ProPAC once again endorsed these conclusions and reaffirmed its strong position on the need for this adjustment.

D. Despite this independent correlation, several observers have suggested that the indirect teaching adjustment is intended to compensate at least in part for "disproportionate share status". It is therefore also important to underscore the findings of AHA, AAMC and others that only about half of all teaching hospitals can be considered "disproportionate share" providers.

E. Similarly, we believe there are also disproportionate share hospitals without teaching programs, who may well be in the worst shape of all under the PPS system.

We believe we can point the Committee to a number of extra services we provide and costs we incur in four principal areas, as possible factors contributing to these higher costs. (Chart 4)

III. It Should Therefore be Clear, As ProPAC and Almost Every Other Party Has Urged, That Implementation of a Concrete Statutory "Disproportionate Share Hospital" Adjustment is Necessary to Correct Certain Inequities in the Present System

Moreover, such a step is essential if Congress chooses to make other reductions in the Medicare Program this year, such as a reduction in the indirect teaching adjustment. In that regard, several issues remain to be addressed: (Chart 5)

A. How do you most accurately and consistently measure the proportion of low-income patients?

1. We believe that Medicaid alone is an inadequate measure of the proportion of "low income patients". (Chart 6) See also Table 1, which compares the relative proportion of Medicaid revenues and direct governmental subsidies of major public hospitals in different states, showing clearly the inequitable differences among states with regard to Medicaid coverage.

2. We believe that all low income patients should be counted in determining whether a hospital is a "disproportionate share" provider, and not just Medicare patients, as the higher costs of serving all such patients are usually impossible to separately identify for Medicare patients alone.

3. Adding "bad debt" and "charity care" to Medicaid to develop an equation used to determine a hospital's relative "disproportionality" would probably be the most accurate measure. (Chart 7) However, we acknowledge that the quality of self-reported bad debt and charity care data, such as in the AHA Annual Report, may be a problem, although we do not believe it is an insoluble one.

4. Alternatively, we believe the approach adopted last week by the House Ways and Means Committee, measuring Medicaid and Medicare-Medicaid crossover admissions, together with a limited appeals process for hospitals whose situation is not accurately described by this proxy, solves a number of the problems generated by use of Medicaid data alone. If this Committee chooses to adopt that measure, we would recommend that the

Medicaid data itself be further corrected for the relative difference in coverage among various Medicaid programs.

B. Once you have identified an appropriate measure, what kind of adjustment should be provided?

1. We believe a continuous or sliding-scale adjustment, which would provide a higher adjustment for a more disproportionate hospital, is preferable to a single fixed adjustment which might be provided to all hospitals meeting a particular definition of "disproportionate share". This is the kind of adjustment approved by Ways and Means.

2. If a sliding-scale is adopted, the question remains as to the most appropriate threshold for triggering a hospital's initial entitlement, such as the national average of whatever indicator is selected, or some higher level of low income effort. Put another way, how many hospitals should be eligible for such an adjustment? (Chart 8)

3. What should be the actual level (or amount) of the adjustment? For example, the House Ways and Means Committee would increase the federal portion of a hosital's payment by .7% for each 1% increase above the national average in a hospital's proportion of low-income patients.

4. What should be the total cost of this adjustment to the Medicare Program?

We do not have answers yet to all of these questions, but we do not believe answers will be difficult to find.

We would like to close with a brief additional comment on the interim final regulations published by the Administration on July 1, in response to a federal court order in Redbud Hospital District v. Heckler. As you may know, the Department was turned down in its effort to get the 9th Circuit Court of Appeals to grant an emergency stay of the effect of this order, but has now appealed successfully for such a stay to U.S. Supreme Court Justice Rehnquist.

While the stay thus has the effect of halting these current administrative efforts, pending a substantive appeal of the lower court's order, we understand some consideration may be given to enacting a requirement similar to that contained in the July 1

regulation. In summary, we believe that process to be severely deficient in several respects. No specific criteria are set forth for hospitals seeking to apply for an adjustment. No level of adjustment is proposed or methodology established for setting one. No assurance is given that any adjustment could even be "justified" -- indeed, quite the opposite impression is given, with the pronouncement that the Department continues to believe such adjustments are inappropriate. For these reasons, if a case-by-case appeals mechanism such as this one is going to be considered by this committee, a great deal of work would remain to be done.

We look forward to working with you on this important matter, and we will be happy to answer any questions you may have.

CHART 1

PPS Alone Does Not Adequately Account for:

- Severity of Illness
- Multiple Diagnoses
- Multiple Procedures
- Inner City vs. Suburbs
- Differences in Case Mix
- Extraordinary Circumstances
- Disproportionate Share of Low Income Patients

CHART 2

Disproportionate Share Hospitals Have Higher Costs (100 Largest SMSAs)

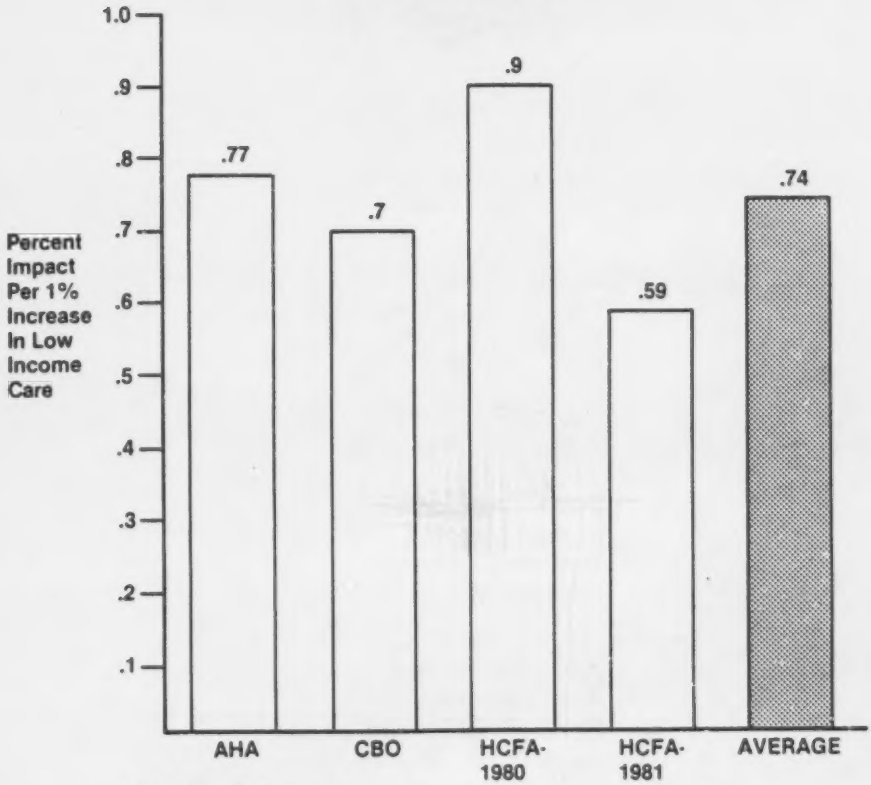
	High Volume Care to Poor	Low Volume Care to Poor
Cost Per Inpatient Day	$277.05	$235.14
Bad Debt & Charity Care as Percent of Charges	10.9%	2.9%
Net Operating Margin	−2.6%	+3.4%

"High Volume" > 13.54%
"Low Volume" < 7.54%
} Medicaid, Bad Debt and Charity Care

Source: Urban Institute

CHART 3

Impact of Serving Low Income Patients on Medicare Costs Per Case



Low Income Factors:

AHA: Medicaid, bad debt & charity as a percent of gross revenues

CBO: Medicaid, bad debt & charity as a percent of charges

HCFA: Medicaid, "self pay", and other governmental admissions.

CHART 4

What Services Account For Higher Costs In Disproportionate Share Hospitals?

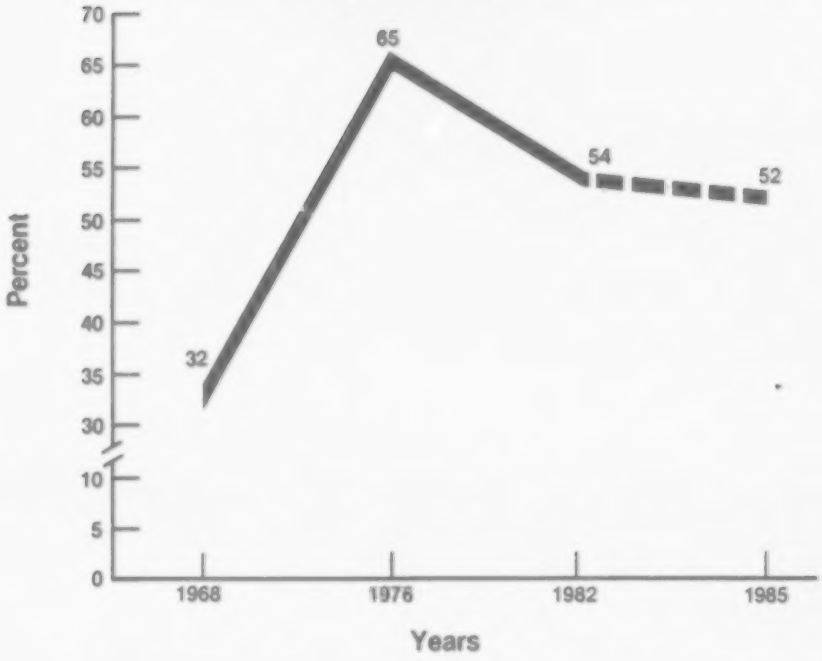
- Need to Treat Sicker Patients
  - Multiple Diagnoses
  - Multiple Procedures
  - Postponed Care
  - Fewer Elective Surgeries
- Special Discharge Problems
  - Lack of Long Term Care Beds
  - Inadequate Home Setting
  - More Chronic Illness
- Extra Services Needed
  - Admission & Eligibility
  - Security
  - Translation
  - Transportation
  - Nutritional Services
  - Prevention & Education
- Higher "Standby" Costs
  - Ambulatory Care
  - Shock/Trauma
  - Specialized Tertiary Services
  - Adolescent Pregnancy
  - Poision Control
  - Substance Abuse
  - Psychiatric

"Disproportionate Share" Adjustment: Implementation Issues

- Measuring "Low Income Patients"
  - Medicaid Alone
  - Medicaid, Bad Debt & Charity
  - New Cost Report?
- What Kind of Adjustment?
  - Fixed
  - Sliding Scale
- What Threshold for Hospital Entitlement?
  - How Many Hospitals?
- Level and Total Cost of Adjustment

CHART 6

Medicaid Recipients as a Percentage of the Poverty and Near Poverty Population* 1968-1985



* Less than $12,480 income for family of four, 1982

Source: Center for Health Policy Studies, Georgetown University

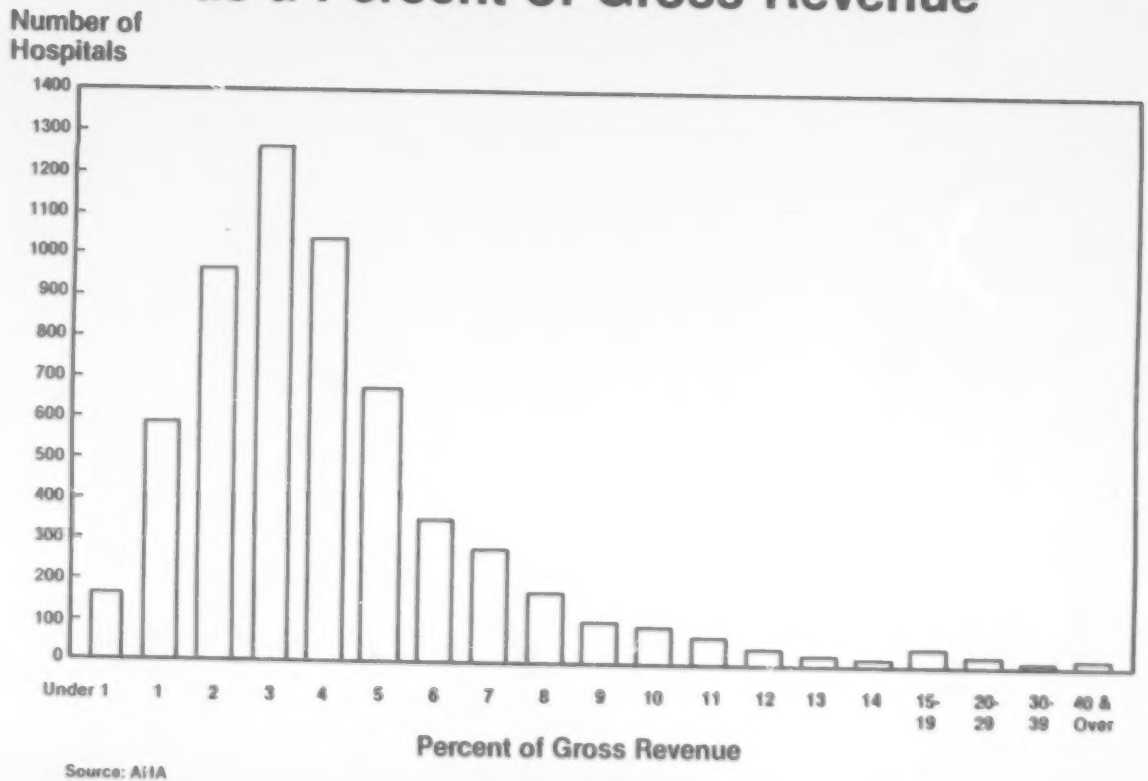
CHART 7

Characteristics of Hospitals Above the 90th Percentile of Care to the Poor (23% or more)

	Charity	Bad Debt	Medicaid	Total
100 Largest Cities (#'s)				
Public - Coth (44)	9.25	14.32	22.04	45.61
Public - Non-Coth (29)	13.63	15.26	18.29	47.18
Private - Coth (35)	2.49	3.45	25.39	31.33
Private - Non-Coth (82)	1.22	3.63	29.06	33.92
Rural				
Public (114)	1.28	10.77	12.49	24.53
Private (26)	1.55	3.74	23.25	28.55

Source: Urban Institute

Hospital Bad Debts/Charity Care as a Percent of Gross Revenue



Source: AHA

CHART 8

TABLE I

SOURCES OF REVENUE AS A PERCENT OF TOTAL REVENUE
NAPH MEMBERS

Hospital	City/County & State Appropriation	Medicaid	Medicare	Private Insurance	Other*
Harris Co. Hosp. District	88.4	4.4	4.9	2.2	0
University of TX Med. Branch Galveston	70.0	3.0	11.0	13.2	2.8
Charity Hosp. of New Orleans	67.6	13.9	13.5	---	5.0
Univ. of TX Health Center - Tyler	61.1	0	27.7	10.2	0
King/Drew Med. Center	60.7	20.8	1.8	4.1	12.4
Cook County	54.3	25.4	10.1	8.1	2.1
St. Louis County	52.2	15.4	20.9	5.9	5.5
Los Angeles Co./USC Med. Center	49.5	31.7	4.1	2.1	12.5
Denver General Hospital	47.0	10.9	16.2	10.4	15.2
San Francisco General	42.3	27.8	16.3	8.9	4.4
Harlem Hospital	39.4	31.0	20.4	3.9	5.3
Alameda County	37.2	34.0	12.8	4.7	11.3
Grady Memorial Hospital	37.1	22.4	21.0	11.1	9.9
Dallas Co. Hospital District	33.3	5.5	12.5	13.3	35.1

* May include some state or local subsidy.

Hospital	City/County & State Appropriation	Medicaid	Medicare	Private Insurance	Other
R.E. Thomason, El Paso	33.2	8.3	12.4	23.6	22.3
Truman Medical Center	31.7	24.3	20.8	13.2	9.9
Contra Costa Co.	28.4	35.8	19.7	3.1	12.7
Queens Hosp. Center	28.4	35.4	20.8	6.7	8.7
D.C. General	25.1	17.8	10.9	5.4	18.2
Chope Community Hosp. San Mateo	24.8	22.4	19.6	13.2	20.0
Bellevue	21.8	43.5	17.0	7.3	10.4
Kern Medical Center	21.5	45.5	12.8	16.9	3.1
Harbor/UCLA	21.4	45.7	11.9	7.5	7.3
Regional Med. Center Memphis	20.9	16.3	7.3	2.7	22.8
Santa Clara Valley Medical Center	19.2	37.7	20.7	21.5	.8
Bronx Municipal	19.0	40.0	23.9	8.3	8.8
San Joaquin County	19.0	44.2	17.4	7.4	11.8
Wishard Memorial Indianapolis	18.9	13.6	19.1	12.4	36.0
Milwaukee County Medical Complex	15.3	11.6	31.1	28.2	13.9
Riverside General	14.8	43.6	11.6	12.1	17.7

Hospital	City/County & State Appropriation	Medicaid	Medicare	Private Insurance	Other
Maricopa Med. Center, Phoenix	14.7	0	18.4	.2	66.7
Amarillo Hospital District	14.2	3.9	16.8	60.1	5.1
Univ. Hosp., Newark, New Jersey	12.2	20.8	10.6	11.5	44.9
Cleveland Metropolitan General/Highland View Hospital	12.1	30.8	24.5	---	32.6
Univ. Hosp. of Cincinnati	11.6	11.0	24.0	31.2	22.2
Univ. of New Mexico Hosp.	11.6	15.7	21.1	36.1	21.1
Westchester Co. Med. Center	11.2	28.4	19.4	27.1	13.9
Harborview Medical Center	10.3	35.6	24.9	7.5	21.7
San Bernardino	9.9	36.6	18.6	6.8	28.1
Ventura Co.	9.6	31.6	11.4	47.1	0
Spartanburg General Hosp.	8.0	4.4	44.1	39.0	4.4
Valley Med. Center, Fresno	6.5	46.0	22.9	10.9	13.7
Brackenridge	6.4	6.4	28.2	58.7	.4
Memorial Med. Center, Savannah	3.9	10.3	33.1	30.2	22.5
Boston City Hospital	3.5	53.6	21.4	21.1	.5
Hurley Med. Center, Flint	0	27.7	37.4	18.1	11.6

Senator DURENBERGER. Let me ask all of you a couple of questions. First, do you have any idea how many hospitals are going to apply for an exception based adjustment under the interim rules, assuming they stay in effect?

Dr. MONGAN. I can only back into an answer to that question. Most of these estimates show that there are some 800 or so hospitals that would potentially benefit from an adjustment that is constructed. So I would assume that a fairly heavy percentage of those would apply. So I think you would see something in the area of 500 or 600.

Mr. OWEN. Possibly as many as a thousand, but 800 would only be eligible probably. I would guess that more would apply than would be eligible. Hospitals would be doing just what they normally do.

Senator DURENBERGER. And according to Jim Mongan, none of them are going to get it approved.

Mr. OWEN. Well, I would not disagree with him on that.

Senator DURENBERGER. Dr. Bentley, any idea of your member hospitals?

Dr. BENTLEY. No, I don't have the answer.

Senator DURENBERGER. Earlier in the hearing the administration, CBO, and PROPAC discussed possible measures to use if we institute a PPS adjustment. I wonder if each of you for the record, if that is possible, if they could be quickly summarized, would indicate the advantages or disadvantages of the various measures that they have suggested.

Mr. OWEN. Well, I guess I could start out. We would support what PROPAC is recommending. We would like to see the proxy as wide as possible, as large as possible, to take into account any problems that some hospitals might have that didn't fall into that crossover. But we certainly would support the PROPAC approach.

Dr. BENTLEY. On behalf of the AAMC, I would have to say that while I've had a chance to review the PROPAC recommendation in some detail because of the length of time that it has been available and that we could support it, I would have to ask for some additional time to look at the CBO analysis, which were distributed with the testimonies as we came in the room. I would like a chance to study that. I'd be glad to comment for the record or meet with your staff, but I don't think I'd be in an informed position to do so now.

Senator DURENBERGER. All right.

Dr. MONGAN. Senator, I, too, would support the PROPAC approach. There is a flavor in the room this afternoon of the best becoming the enemy of the good. I mean it is true that none of these are perfect adjustments, but all of them point in the same direction and they are all pretty close quantifiably. And I think the PROPAC recommendation is a good one.

Senator DURENBERGER. All right.

Do you have any idea about what is going to happen in the situation—assuming we set up a PPS adjustment that is better as opposed to best—in a situation, as I understand exists or existed in Tulsa, OK, which I am told is the largest city in the country that does not have a public hospital. You have three major private hospitals that informally share the cost of uncompensated care in that

community. And lately there is another type of private hospital—Oral Roberts is getting into the business.

Is it likely that a community like Tulsa may change the way it is currently reacting to the needs of the indigent or those who are less economically advantaged based on what we do with the adjustment?

Mr. OWEN. I would doubt it very much because this program is not paying for the poor. It is not increasing the Medicaid payment. It's not paying for those that don't have Medicaid. It's not paying for the charity care. All it's doing is recognizing in those instances where there is a difference in the Medicaid there would be an added amount, which may be, depending on what we end up with, but might be as much as maybe a 7-percent increase in the Medicare price. To take more patients in which you get paid nothing in order to get 7 percent more for your Medicare doesn't make any sense. I can't see any hospital wanting to do that. I don't understand, I guess, the rationale of why hospitals would want to shift and take a lot more poor people in who don't pay so they can get more from Medicare when you get such a small percentage on the Medicare price.

Dr. BENTLEY. If I could expand on that. I disagree a little bit. I think there is a possibility. One has to understand the hospital's own economics: its occupancy and the difference between its average revenue and its marginal cost. It is conceivable to me that, on a purely economic basis in the short term, the hospital would be advantaged if there were such an adjustment; particularly, if the adjustment overpaid the average cost. The analysis I have seen to date by CBO, PROPAC and others doesn't lead me to believe that it's going to overpay the average cost of caring for those patients. Thus, I don't think you will create, if you will, a market in which hospitals chase those kind of patients.

Beyond that, I think the point that Mr. Owen makes is a very good one. A hospital is not in the position to be able to go out in the community very easily and have, if you will, the best of the adverse selection; namely, only those poor patients who happen to be Medicare patients. To some limited extent you can do that with the development of services heavily used by Medicare patients. Perhaps a hip replacement program, if you were to adopt it, could tend to draw more of the Medicare patients.

But I would be surprised if the kind of adjustment in the level you are talking about where it's based on real costs that hospitals have historically had to carry, would lead to a change in the pattern and distribution of patients. I don't see hospitals with a low percentage of charity care patients or low percentage of Medicare aged and indigent patients using these adjustments to change their character in the community when the higher your percentage of the old-poor or of the poor in general tend to disadvantage you in a truly competitive market.

Senator DURENBERGER. Before I ask Jim Mongan to reply, both of you are looking at it from a standpoint of decisions taken by hospitals, which is, I think, the way I presented the question. But that, in effect, was not—Tulsa was not only a decision taken by hospitals, it was a community decision.

Mr. OWEN. Right.

Senator DURENBERGER. So, I'm thinking about the situation in which the community in some degree of informal planning is involved in taking care of the poor. The community makes the decision that, well, look, Medicare has this 7-percent adjustment that we don't now get. Right now, the community is taking care of the problem one way or another. Everybody bites a little bit into the bullet and somehow the community is taking care of the problem.

Now we come along and take a little bit from everybody in order to create this new category; community says to itself, now you, go be the disproportionate share hospital and we will back everybody else out of the business and all of the elderly poor will now go to that hospital. What have we gained by that? Or is that not likely to happen?

Dr. MONGAN. I guess I tend to agree with the other gentlemen, Senator, that it's not likely to happen. I mean the political dynamics in a community are such that to get the force to designate one hospital to be the one that is bearing all of this burden, if it's not now happening, is a pretty tricky undertaking to pull off. So I seriously doubt that you will see that happen.

Mr. OWEN. I can see a possibility I can cite an example from a rate-making State, having come from New Jersey, where the counties which are responsible for the so-called poor and needy dropped their payment once it became known that bad debts, charity care, and so forth would be picked up as part of the price set by the rate commission. I can see something like that maybe occurring. If there is a total pick-up of the costs of that indigent patient, a State or local government then pulling back away saying, well, if somebody is going to pay for it, why should we. We will use our taxes for something else.

But this particular case, the increment is so small and it's across that is already there—it's not something new that wasn't there. It's equity in what is already existing—I don't see local governments taking this position unless they take the position that you are going to be the county hospital and then we are going to subsidize you for all of those patients through taxes, which then becomes a county or municipal hospital or a public hospital that is tax afforded.

Senator DURENBERGER. But that's what is going to happen. I mean it is pretty clear to me that John is over here talking about Cook County. You can talk about all the public hospitals around this country. That's what is going to happen with this thing, isn't it? We are going to create this little 7-percent add-on or whatever it averages out to and the communities are going to send the elderly poor or the Medicare eligibles to the public hospitals, if they have got one.

Dr. BENTLEY. It's conceivable, and maybe I am naive, but I think there are a variety of factors that will work to ameliorate that. One is no matter what the hospital wants to develop, it still has to work with and through its medical staff. And if we are going to say that all the patients in community X have to go to a particular hospital, that's also moving patients across physicians.

Second, I hope that the market incentives that we have seen some benefit from in the health care system in the past couple of years have not so changed the orientation, particularly for those in

the not-for-profit hospital community, that they simply are going to take every action based on economics. I would like to think that there still is a goal of community service; that there is a goal of trying to take care of the local community and meet its needs out there. I may be in the wrong occupation if that's not true, but I think that's out there. I sit on the finance committee of a hospital here in the metropolitan area. There are a number of business executives from the community on that finance committee. It is very clear that the only reason they are donating their time to that hospital, as opposed to other organizations in the community, is they feel that hospital has a community mission. If they were told that that hospital is now to behave solely in an economic vein, they would find another organization to donate their time to. So I don't think it will happen.

Senator DURENBERGER. Nobody is going to say it's an economic decision. Everybody says the poor are better taken care of, the elderly are not, in the public hospitals. We all know that. That is the line, isn't it? I mean you do care more in these hospitals? I'm sure nobody is going to say it's an economic decision. They are going to say they can get better care at the local general hospital or whatever. And that will become the justification for aiming the funnel in that direction.

I see the panel disagrees with that, but I wish you would think about it a little bit.

Dr. MONGAN. I may have misunderstood it the first time around, Senator. If what you are implying is that somehow giving is what I obviously consider equitable relief will be viewed as a legitimation of further dumping, I guess I'm at a bit of a quandry about how to respond to that because I obviously don't like where it leads.

Senator DURENBERGER. That's the part of the issue I'm raising. And I use the Tulsa example as a community that the last time I visited it, was adjusting in one way or another to the opportunities of prospecting pricing, but also in having to incorporate in that the difficulties of dealing with the impact the new system has on the indigent.

Dr. MONGAN. I mean I think you get back to two basic points. First off, I hope you understand my discomfort with the logic that by giving the relief you deserve, we are going to cause this other thing to happen and, therefore, we shouldn't do it. But, in addition, I guess I do find rather compelling the argument that we are talking about a marginal adjustment as opposed to the very much higher costs, whether you are talking about actual cost or marginal cost, of actually taking on the additional patients.

Senator DURENBERGER. Jack Owen, PROPAC has suggested the need for an adjustment that would raise or lower hospital PPS payments based on how much the poor population is covered by the State's Medicaid program. And you made some reference to this earlier.

Mr. OWEN. Yes.

Senator DURENBERGER. Had you considered such an adjustment, and if so, why did you not include it or use it instead of your uncompensated care adjustment?

Mr. OWEN. You mean as far as our figures and the——

Senator DURENBERGER. Yes, I guess so.

Mr. OWEN. What we were using was a ratio, a proxy on revenue. We had that available. The basis of Medicaid, charity care and bad debts. And as we compared what we were doing with what PROPAC and CBO were doing, we were not that far off in the difference. For instance, there aren't too many hospitals that swing if you go either route. The only problem is you just use a straight Medicaid without the cross-over, and then you have—well, what PROPAC wants to do—you do limit in those States where there is a problem with eligibility and a lessening of the number of people who would fall into the Medicaid category. There was no reason why on our part for doing it because we had the figures and it was an easy way to put it together.

What we are looking for is, again, some method. We have been frustrated because everybody keeps saying, yes, there's a problem, but nobody wants to come up with any kind of an approach to the problem. And this looked like as good an approach as any. But we welcome looking at any approach, as long as something is done.

Senator DURENBERGER. Dr. Bentley, your testimony indicates that we need more PPS payment rate adjustments to recognize differences among hospitals. In addition to the disproportionate share adjustment, what further adjustments do you feel are needed? Would not the inclusion of more adjustments move the PPS system back closer to a cost-based reimbursement system?

Dr. BENTLEY. The quick answer to the latter part is yes. To the extent that one can identify systematic patterns of variation in costs across groups of hospitals, I don't think that movement back is inappropriate. There have been a couple of things I have seen that I think could be quickly done that would improve the adjustment. Now that HCFA has the data on hospital wage patterns, it would be possible for HCFA to develop wage indexes for smaller community areas than whole metropolitan statistical areas. Second, the Rand study of coding includes a very clear statement that the impact of age as a variable in the cost of treating patients has not been fully recognized in the DRG system. Those hospitals that treat the young-aged are receiving a windfall while those hospitals that receive the old-aged are receiving a penalty.

Third, the developers of the DRG system have suggested numerous reclassifications and coding improvements that they would recommend HCFA make. HCFA has made only a small set of them in its proposed regulations. I think these kinds of adjustments can be done with the information we have at hand. They can pick up some of the differences that are out there, and differences that I personally would regrad as legitimate.

Mr. OWEN. I would like to comment just a second on that because I think going back to the old cost system would be a mistake. And I don't think anybody wants to do that. I think—if I can put words in Jim's mouth—we are looking at is cost as a proxy for establishing a price, just like we are doing with disproportionate share. I think that's what we are more interested in than moving back to a cost reimbursement system. I think those days are gone, and I think all the incentives and all the reasons we all know about should not come back again.

But there is a reason for a better market or competitive rate than just taking it flat, across the board.

Senator DURENBERGER. Dr. Bentley, on the measurement, you indicated your obvious preference for patient volume rather than dollar revenue. What are the ways in which dollar revenue measures can be manipulated?

Dr. BENTLEY. I guess there are two ways in which dollar measures can be manipulated. If you look at some of the data we have seen on some of our members, we have hospitals that have a 12-percent markup and we have hospitals that have a 70-percent markup on their prices. To the extent that a hospital has that 70-percent markup, when you begin to look at what is happening in terms of the way different programs would pay, based on the contractual adjustment, it's possible to have a hospital which I would personally regard as a relatively low disproportional share hospital appear as if it is a high one.

The second way, and I would agree with Dr. Altman that it has very modest impacts, is the attempt to set different prices for different services in a way such as to maximize Medicare reimbursement. The one thing I would add to what he has said is to the extent that has been an incentive in the old system, it has not been limited to disproportional share hospitals. There is a gentleman, I believe his name is Don Heddinger who used to work for HCFA, who did a whole series of studies showing the way in which hospitals could and did price their services to maximize their Medicare revenue. So I don't think your concern that this could account for the higher cost observed in public hospitals or in disproportional shares is probably true. That may be true in a wide variety of hospitals. All hospitals share that incentive.

Senator DURENBERGER. Jim Mongan, the PROPAC and CBO analyses show that for rural hospitals after a certain point costs per case in fact decrease as the number of low-income patients increases. Do you have any idea why?

Dr. MONGAN. I don't have any idea for the decrease. Jack and I were talking earlier. I think I understand why the increase doesn't show. That's because they simply have not had the resources to get the complex, technical equipment or hire the extra staff. So they have a sicker patient. But they haven't had the ability to get the resources to deal with that. So, I'm not surprised it doesn't go up. I do not have a good explanation for a decrease.

Senator DURENBERGER. Anybody else?

[No response.]

Senator DURENBERGER. Your testimony indicates that payments to NAPH hospitals will fall 4 percent under the freeze that HCFA proposed in its interim regulations. What specific things in the regulations would cause those hospitals to suffer that loss?

Dr. MONGAN. I believe in the testimony that was illustrative. Not all facilities in the aggregate. And it was the reduction of the teaching payment and the transition.

Senator DURENBERGER. All right.

Gentlemen, thank you very much for your testimony. I think we have covered the subject very well today, and I'm most grateful to you for your help.

The hearing is adjourned.

[Whereupon, at 4:03 p.m., the hearing was concluded.]

[By direction of the chairman the following communications were made a part of the hearing record:]

Statement of

Merlin K. DuVal, M.D., President

American Healthcare Institute

before

Subcommittee on Health

Senate Committee on Finance

July 29, 1985

"HOSPITALS SERVING THE POOR AND ELDERLY"

The American Healthcare Institute, which represents 34 voluntary hospital systems across the country and includes over 300 hospitals, is pleased to have the opportunity to comment on the speical problems of hospitals serving the poor and elderly.

The voluntary hospitals we represent take very seriously the mission of making good health care available to all members of our society. Voluntary hospitals began in this country as a complement to public hospitals, and in some cases as a substitute for public hospitals. Many were begun and are still operated by religious organizations or local community groups who believe that health care is a special human need and that religious beliefs and basic humanitarian instincts require that health care be available to all. They also believe it should be delivered in a context of community concern and caring. Today, still, we are especially proud of member hospitals who have entered poor communities to offer health care that would otherwise be provided by no one, or by a public hospital many miles away.

But this is only half of the story. The voluntary hospitals we represent are also committed to responding to the needs and demands of Americans as expressed in a more competitive health care marketplace. We agree with government and private purchasers of health care that hospitals must find ways to constrain the future growth of health care costs, and our hospitals are prepared to compete in the healthcre marketplace

based on our ability to constrain costs. We have members who are national leaders in changing the patterns of care offered to patients, and in increasing their own efficiency and productivity.

Our members' voluntary heritage and commitment to marketplace competition do not always rest easily together. As our hospitals or developing health care organizations compete with other health care organizations in a price competitive environment, we are forced to confront how our community service mission increases our costs and forces up our prices. As our members perfect their skills as competitors, to ensure enough revenues to support our traditional missions, they start to wonder if they are health care providers or businesspersons. One hears discussion throughout our system of whether we are providing "care" or a "product."

The challenge to the voluntary hospital is to assure that what our competitors talk about as a "product" is delivered as what we as providers know as "care," and that care is provided to anyone who needs it. Our success in meeting this challenge is important to society in many ways, not the least of which is that if we fail, many more public hospitals will be needed in the country.

Because of its size Medicare's reimbursement policy has an important impact on all hospitals. We cannot afford to collect less than a fair price for Medicare patients and still sustain our mission. By a "fair price" we mean a price that reflects the resources consumed by an efficiently operating hospital in a price competitive market.

Medicare's prices are averages of the resources consumed by various types of hospitals to provide care for different types of admissions. Some rough adjustments are made to allow for legitimate factors that affect their costs, such as the area wage adjustment, and the indirect medical education adjustment. These adjustments are imperfect and do not recognize the increased Medicare costs for treating low-income patients, or operating in a low-income community.

Short-Term Recommendations

We, therefore, support an immediate adjustment in Medicare's DRG prices for hospitals who treat a large proportion of low-income patients. Sufficient data are available on which to base an adjustment initially, with refinements possible in the future.

The approach taken by House Ways and Means Health Subcommittee to this problem is a viable one, with two exceptions. First, it assumes that only public hospitals find themselves in a position of treating large numbers of low-income patients who are not

eligible for Medicaid. Voluntary hospitals also find themselves in this situation and, incidentially, aren't appropriated any state or local revenues to support this burden. Voluntary hospitals in this situation, like public hospitals, should be entitled to appeal to Medicare for DRG price adjustments--and on some basis other than the percentage of their revenues received from state and local governments.

Second, the House proposal is restricted to urban hospitals of 100 beds or more. It is clear that there are rural hospitals who care for a high proportion of low-income patients. We understand that an analysis of the number of Medicaid patients in rural hospitals failed to account for differences in costs. We suggest that the problem is in the data or the analysis, and we urge that rural hospitals be included in both any DRG adjustment based on percentage of patient days attributable to Medicad patients, and in any special appeals process based on other low-income patients.

Long-Term Recommendations

In the long run, we suggest that further analysis of Medicare experience and hospital resource use can improve our ability to produce fair DRG prices. In this regard, we are increasingly convinced that the geographic location of a hospital and/or its service area will prove to be a more accurate indicator of

legitmately higher costs than Medicaid eligiblity. While area wage adjustments get at some of this variation, they do not define geographic areas finely enough, and wage differences are only part of the problem. We would suggest a study of whether classification of a hospital's service area in terms of per capita income, Medicaid eligibility, populaiton density, and other factors would be useful in explaining variations in hospital resource use.

Our hospitals believe that Medicare's best long-term course is, in fact, paying for health care on a capitation basis. Ultimately, the experience government gains in perfecting DRG prices can be put to use in refining capitation payments under Medicare. We believe we will have gretest flexibility to both pursue our mission and compete in the marketplace under such an arrangement, and are anxious to help you to this end.

Summary

Mr. Chairman, voluntary hospitals face a great challenge in both continuing their public mission of service and competing in the health care marketplace on the basis of price. Our success is important to our communities, to the health care field generally, and to government. It would be unwise policy for government to underpay for services to its own Medicare beneficiaries in low-income areas.

AMERICAN MEDICAL RECORD ASSOCIATION

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EXECUTIVE OFFICE

STATEMENT OF

THE AMERICAN MEDICAL RECORD ASSOCIATION

Prepared for the Senate Finance Committee
Hearings on the "Medicare and Medicaid Patient and
Program Protection Act of 1985"

The American Medical Record Association welcomes the opportunity to comment on the "Medicare and Medicaid Patient and Program Protection Act of 1985." AMRA represents 26,000 medical record professionals responsible for the maintenance, confidentiality and security of medical records and health information in health care facilities throughout the United States.

We object to two of the bill's current provisions. First, Section 2, Part 11, "Failure to Supply Payment Information," is unnecessarily broad. As currently written, a health care provider will be excluded from Medicare and State health care program participation for failing to provide any records the

Secretary, Inspector General, or State agency deems necessary to fulfill the purposes of the Act. While we support the authority of the Secretary or State agency to review records of Medicare or State health care program beneficiaries, we believe that the current language opens the door to review of non-beneficiary records. For example, if the reviewer deemed it necessary to compare beneficiary information to bills and medical records of non-beneficiaries who received similar services, the health care provider would be obliged to make those non-beneficiary records available.

Such a disclosure would be inappropriate, and would conflict with numerous State laws governing the confidentiality of health information. But Part 11, combined with the "immediate access" provision of Part 12 (discussed below) virtually forces health care providers to turn over any records requested. The only alternative is to refuse, and risk exclusion from the Medicare and Medicaid programs while attempting to explain why non-beneficiary records should be protected from review.

The problem is easily corrected by explicitly limiting the Secretary's authority to records and information pertaining to Medicare and State health care program beneficiaries. We believe this minor change is consistent with the purposes of the bill, while guarding against inappropriate access to information on

non-beneficiaries.

Our second concern with the bill relates to Section 2, Part 12. Any provider who fails to grant "immediate" access to information upon "reasonable request (as defined by the Secretary in regulations)" will be excluded from Medicare and Medicaid participation. The phrase "immediate access upon reasonable request" presents potential problems for health care providers, and should not be left to the Secretary to define.

The retrieval of records and information for external reviewers is often complicated by numerous other demands upon those records. Patient records are used for a multitude of purposes: to ensure continuity of care upon patient readmission, to evaluate the quality of services provided, for research, and many other purposes. The provider must have enough advance notice of the records that are needed for review so that these records can be made available.

The Secretary's perception of what is "reasonable" advance notice presented a serious problem recently, as manifested in peer review organization procedures. Originally, hospitals received no more than 24 hours advance notice of the reviewer's need for records. The burden this provision placed on health care providers has since been recognized, and the time frame for advance notice has now been relaxed to 48 hours.

Although the reasonableness of any time frame will always depend on the number of records requested, some minimum standard should be specified in the bill to prevent an unreasonable application of the provision. We suggest that the committee specify 48 hours as the minimum standard for advance notification. Anything less almost guarantees the inability of health care providers to comply with the request.

We believe that the changes suggested above will facilitate the timely availability of appropriate information, and will minimize unnecessary conflicts between health care providers and the Secretary, State health care agencies, or other designated reviewers. Please contact us if the Committee requires further information on either of the problems cited above.

AMERICAN MEDICAL RECORD ASSOCIATION

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STATEMENT OF THE
MERCY INNER CITY HOSPITALS FORUM

TO THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE
UNITED STATES SENATE

HEARING ON HOSPITALS
SERVING THE POOR AND ELDERLY

JULY 29, 1985

INTRODUCTION

The Mercy Inner City Hospitals Forum (hereinafter "the Forum") is pleased to have this opportunity to provide written testimony to the Subcommittee concerning the continuing policy debate surrounding the need for, and implementation of, a Medicare payment adjustment for hospitals serving a disproportionate share of low income and Medicare patients. The Forum currently represents ten Catholic-sponsored hospitals located in the inner cities of: Baltimore, Chicago, Cleveland, Denver, Detroit, New York, Philadelphia, Pittsburgh, and Toledo. The mission of the Forum is to strengthen the role of its member hospitals in the provision of health care services to inner city, primarily poor, populations.

BACKGROUND

Since the enactment of legislation establishing the Medicare prospective payment system, the Forum has expressed its strong concern that the Department of Health and Human Services (HHS) has ignored Congress' directive to implement a Medicare payment adjustment for hospitals serving a disproportionate share of low income and Medicare patients. HHS has also failed to carry out a latter directive by Congress, within the Deficit Reduction Act of 1984, to develop and publish a definition of "disproportionate share" hospitals and to identify those hospitals to the House Ways and Means and Senate Finance Committees. By not carrying out either of these directives, HHS has done more than snub Congress, the Department has placed "disproportionate share" hospitals in serious financial jeopardy, thereby threatening the adequacy of care available to Medicare beneficiaries.

In an attempt to force HHS to honor the statutory protection established by Congress for "disproportionate share" hospitals, several institutional members of the Forum filed suit against the Department on February 6, 1985, in the District Court for the District of Columbia. (Samaritan Health Center, et al., v. Heckler, Civ. No. 85-0464.) The plaintiff-hospitals are awaiting a final ruling on the case, however, it is important to note that the Court has already ruled that the Secretary has a "clear, non-discretionary duty to develop and publish a definition of "disproportionate share" hospitals and to identify those hospitals to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate." (Emphasis added.) Accordingly, the Secretary was ordered to develop, by July 26, 1985, a proposed plan and timetable for defining and identifying disproportionate share hospitals. The Court also ordered that the plaintiff-hospitals be given an opportunity to critique the Secretary's proposal.

On August 1, 1985, the plaintiff-hospitals submitted their response to the Court on the Secretary's proposed plan and timetable. Simply stated, the hospitals have opposed the Secretary's plan, which calls for no less than a ten-step program culminating in a final definition of disproportionate share hospitals on June 15, 1986, almost eighteen months after the Deficit Reduction Act's deadline. The hospitals contend that this delay is not caused by difficulties in obtaining and analyzing data, as the Secretary claims, but to a fundamental misconstruction of the Congressional mandate and the Court's order.

The Forum believes that there is sufficient evidence to conclude that hospitals serving a high volume of low income patients (as measured by a

variety of definitions) incur higher Medicare costs per case than other hospitals, and that the higher costs are due to factors beyond the control of these hospitals. (Based on studies conducted by the Prospective Payment Assessment Commission, American Hospital Association, Congressional Budget Office and the Health Care Financing Administration.) As indicated by the American Hospital Association in its testimony before the Subcommittee, the Forum believes that "disproportionate share" adjustments are required as a matter of equity; "Not only is payment equity important to hospitals' sense of fair treatment under prospective pricing, but it also is critical to the availability, accessibility, and quality of needed community health services." Implementation of a "disproportionate share" adjustment is long overdue. Therefore, the Forum urges Congress to reaffirm its earlier directives to HHS by mandating a "disproportionate share" payment adjustment for qualifying hospitals in Fiscal Year 1986.

FORUM RECOMMENDATION FOR DEVELOPMENT OF A "DISPROPORTIONATE SHARE" ADJUSTMENT

The Forum recognizes the fact that before a payment adjustment can be initiated, it first is necessary to establish an appropriate proxy measure for "low income patients." In this regard, a number of proposals have been suggested, each one having strengths and weaknesses in terms of its ease of implementation, and responsiveness/equitable treatment of the issue. Taking these factors into account, the Forum recommends that the proxy for measuring an institution's commitment to serving a low-income population be based on the sum of the following three variables:

1. **Medicaid revenues as a percentage of a hospital's gross patient revenues.**

   Such a measure is readily available and most accurately reflects

total resources devoted to the care of low-income, Medicaid patients -- both Medicaid-only and Medicare patients with Medicaid as a secondary source of coverage.

2. **Revenues received through welfare and state/local hospitalization programs for low-income persons as a percentage of a hospital's gross patient revenues.**
   This variable would help to account for low-income patients not covered by Medicaid, and would correct for differences in the scope of state Medicaid programs. This information is also readily available and subject to audit.

3. **Bad Debt and Charity Care as a percentage of a hospital's gross patient revenues.**
   The amount of uncompensated care provided by a hospital is typically an accurate indicator of its commitment to low-income populations, as are the variables described previously. Specific standards for reporting uncompensated care can be developed easily, along with requirements for verfication of this data, by Medicare fiscal intermediaries.

Using the sum of these variables as the proxy measure, the Forum further recommends that all hospitals which serve more than the "national average" of low-income patients qualify for a payment adjustment under the "disproportionate share" provision, and that qualifying hospitals receive a payment adjustment in proportion to their "share" of low-income patients.

i.e., hospitals which serve a higher proportion of low-income patients should receive a larger payment adjustment.

CONCLUDING REMARKS

In concluding its remarks, and in support of the recommendation presented, the Forum wishes to respond to testimony provided to the Subcommittee by the Health Care Financing Administration. Of particular concern to the Forum is the following statement: "We believe that it is fairer to continue the current method of PPS payment, with its assumption that all hospitals serve an average proportion of low-income patients, than to make an adjustment that redistributes hundreds of millions of dollars based on an arbitrary definition of a disproportionate share hospital."

In response to this statement, the Forum would like to point out that the entire history of the prospective payment system has been based on hypothesis derived from somewhat theoretical models. It is eminently fair to assert that PPS is still an experimental effort to reform Medicare. Everyone involved -- from Congress to HHS to the hospitals and doctors -- is learning from the PPS experience as it unfolds. The Secretary's reluctance to produce a mere definition and list -- a first step toward implementing the disproportionate share component of prospective payment system -- is based on an alleged concern that the definition and list must be far more precise than the overall PPS program. And, in relation to total Medicare program costs, estimates of dollars to be redistributed under the "disproportionate share" provision are much less than those which have been targeted for other program components. Within this context, the Forum believes that such a concern hardly suggests a reason to defy Congress' mandate.

Disproportionate Share Hearing - 7-29-85

Edith Irby Jones, M.D.
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Committee on Finance
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HOSPITALS SERVING THE POOR AND ELDERLY

Disproportionate Care Hospitals: Implications for Health Care Access

Edith Irby Jones, M.D., President
NATIONAL MEDICAL ASSOCIATION

The National Medical Association at its 90th Annual Convention in Las Vegas July 20-25, 1985 considered the issue of Disproportionate Share Hospitals and the Implications for Health Care Access.

I am mailing to you a paper I presented at that meeting which I would like to enter as written testimony for the Hearing on Hospitals serving the poor and elderly held July 29, 1985 by the Legislative Committee on Finance.

I want to first define "disproportionate share hospitals" and then show the correlation between them and hospitals labeled "financially distressed". By comparing the two and examining the largely ineffective measures used to cope with the problems of both, we can better see the negative impact upon patient access.

Finally I have some suggestions - some possible solutions, for these problems. I do not mean to propose that these solutions are all-inclusive - I do not have all the answers. Too, these solutions may not prove workable. What I hope to do is plant some seeds.

What is a "disproportionate share hospital"? It is a hospital which treats a higher than average number of patients who have little or no resources to pay for that care or who have less comprehensive insurance, for example Medicaid or Medicare. To the extent that we treat many of these same patients, I suppose that we could be called "disproportionate share physicians".

Now, what is a financially distressed hospital? Well the Hospital Cost and Utilization Project of the National Center for Health Services Research, the source of much of my statistical data, says: Now listen to this,- they are just like E.F. Hutton - "an institution with a negative total income ratio over three years". So if a hospital loses money for three years consecutively they are "financially distressed". Isn't that a wonderful definition. Many of us live that definition. Infact, over one fourth of the nation's voluntary hospitals (non-proprietary and non-government) are in serious financial trouble.

There are some characteristics common to both the disproportionate share and the financially distressed hospitals:

1. Higher than normal bad debt losses
2. Higher than normal percentage of patients covered by Medicaid, Medicare and Blue Cross. You may be surprised to hear Blue Cross here. Some researchers believe that it is due to Blue Cross's willingness to insure residents of economically disadvantaged areas, which may be less attractive to commercial insurers.

3. Higher than normal percentage of patients who are poor and aged.
4. Somewhat longer than average lengths of stay for patients - about a day or longer.
5. Higher average charges per admission.
6. Higher than average percentage of outpatient activity.

These six points come from research on both the disproportionate share and financially distressed hospital. These two categories of hospitals have a lot in common. And although these depressing facts are based on research - they are things we could easily predict. When you primarily treat the poor it takes no genius to know that you will have bad debts and must rely upon Medicaid and Medicare which reimburse inadequately. Those two factors alone can set-up the hospital to be financially distressed, if not now - probably soon in the future.

What are hospitals, both disproportionate share and financially distressed, doing to solve their difficulties? They are doing the same things as other, not-so-labeled hospitals, do in an effort not to get "the label". As I list the tactics I'll elaborate on their impact upon patient access and quality of care.

First--Cost-shifting. This is the process of transfering the losses form one segment of the patient population to another segment which is better able to pay. In other words transferring the loss from the poor to the less poor. Aside from the legal, or should I say

illegal implications of this technique, how much longer can the commercial insurers and their policy holders be expected to tolerate the artificially increased costs generated by this tactic? And if a hospital already has few patients who can pay their own way, or have an insurance company that will, how can this cost shifiting work at all? You cannot rob Peter to pay Paul when Peter is already broke.

Second--Increasing charges: We have certainly seen a lot of this lately with the recent hospital cost index climbing at more than twice the overall rate of inflation. But, if you are a disproportionate share hospital and rely on primarily Medicare and Medicaid you cannot use this relief valve.

Third--Quota setting: This approach sets a limit on the number of Medicaid beds available for use in the hospital. Many hospitals have done this, and what happens to the patients they turn away? You got it! We get "em." They come to the disproportionate share hospital and increase the "disproportion" even more.

Fourth--Reduce outpatient services in order to increase inpatient care: A hospital's losses usually come more from outpatient services than inpatient. Why? Well insurers usually reimburse inpatient care at a higher rate than outpatient. This working principle is based on the assumption that if the patient had to be admitted to the hospital, it had to be "serious". But, those of us who have experienced the beneficial impact upon our patients' health due to the recent advances in outpatient surgery, know that more hospital admissions is not the answer for our patients. Too, in the long run this can only lead to higher overall health care costs for the hospital.

Fifth--Reduce capital expenditures: This is like treating the symptom rather than the underlying problem. Capital is necessary to insure adequate equipment, facilities and upgrading of patient services. Without it, the hospital falls into disrepair. Quality of services diminishes. Staff morale falls. Professional staff become disgruntled and can migrate to the "new and better facility down the road". As physicians leave, many of their patients, at least those who can afford to, go with them, leaving even more patients behind who cannot afford to pay. This is a vicious downward circle.

Sixth--Closure is sometimes the ultimate solution for coping with the problems of the disproportionate share and the financially distressed hospitals. The implications for patients access are obvious.

Outright closure is frequently the treatment of choice for proprietary hospitals which are, by definition, in business for profit. If a particular healthcare "outlet" proves consistently unprofitable, the outlet is closed and resources are transfered to a profitable location. What could be fairer to the stockholders of the corporation? Indeed, what could be more unfair to the patient population that facility once served?

All of these so-called solutions have one thing in common--the patient suffers. In this country the poor lack resources in all areas, especially in their search for quality health care. The use of any of these tactics makes their search all the more difficult.

Now let's look at some alternative solutions to the problems of the Disproportionate Share Hospitals. Some are just applications of good common sense - the key is application. Others are new and untested.

First--Better, more cost-effective hospital management. This is one of the common sense solutions. It's obvious that better management can produce a healthier hospital. Not so obvious is how to obtain it. Is there adequate research in the area of hospital management to produce more effective techniques? Are our hospital administrators of tomorrow being adequately trained today and in sufficient numbers? Have some of the newer management techniques such as quality circles, management by objectives, as well as the ideas presented in THE ONE MINUTE MANAGER, been given a fair trial in our nation's hospitals? Or is the response too frequently: "Oh, that won't work in our field; we're different".

Second--Improve the reimbursement rate to hospitals from Medicare and Medicaid. Is this a real alternative? Or are we just beating a dead horse? Our government's stated objective is to reimburse hospitals their actual cost for treating Medicare/Medicaid patients and they must believe they are doing just that. Are they? At this time Disproportionate Share Hospitals receive less per service per patient than do other hospitals.

Third--How about outright subsidies or grants to the distressed and the disproportionate share hospitals? Either at the local, state or federal level. Can we make a strong enough case to convince our legislators that saving these hospitals is a worthwhile investment? And if we do, are we willing to accept the constraints and guidelines that inevitably accompany such grants?

Fourth--And what about grants from the private sector, otherwise known as charitible contributions. Are our hospitals doing everything they can to draw upon the resources of the philanthropic community? What would help them do a better job in this area?

Fifth--Should all hospitals be required to accept their fair share of economically disadvantaged patients? It's a rare hospital indeed that presently accepts no government funds. There, then, is the carrot and the stick for implementation of such a program. But would such an approach really be desirable? Do we really want further government intervention in our hospitals?

Sixth--Should the financially distressed and the disproportionate share hospitals be encouraged to affiliate in some way with their financially stronger counterparts? This could result in a beneficial exchange of management techniques, key personnel and other resources as well. Might this not help the financially strong hospital learn to cope better with the needs of the economically disadvantaged instead of simply closing their doors to them? Could this be an alternative to requiring hospitals to accept their equitable share of needy and underserved patients?

These are just a half dozen ideas for us to ponder. Our panel of experts will surely have more innovative methods to solve the problems these hospital are having to assume. Frankly, I like some more and some less. But until all ideas have undergone close scrutiny by others who are experts in this field, I would not want to support or discourage any of these ideas for fear that the one or two really viable solutions may be discarded at the onset without the benefit of careful, considered and inventive exploration.

I thank you for this opportunity of discussing the plight of the Disproportionate Share and the Financially Distressed Hospitals. I hope I have stimulated and sensitized you to the need for our rescuing these hospitals in order that patients for whom we are the advocates will continue to have access to quality health care.

STATEMENT OF
JOHN J. McLAUGHLIN
PRESIDENT
NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

Before the
FINANCE COMMITTEE
SUBCOMMITTEE ON HEALTH
U.S. SENATE
ON HOSPITALS SERVING
THE POOR AND THE ELDERLY

July 29, 1985

Mr. Chairman, I am John J. McLaughlin, President of the New York City Health and Hospitals Corporation (HHC), a public benefit Corporation responsible for operating New York City's public hospital system. On behalf of HHC and the City of New York, I thank you for your continued interest in the successful implementation of the Medicare prospective payment system generally, and the issue of providing special consideration for hospitals serving a disproportionate share of Medicare and indigent patients —so called "disproportionate share hospitals" —in particular. These are issues of crucial concern to HHC.

HHC is the largest public hospital system in the country. The Corporation operates eleven acute care hospitals, which handled approximately 236,000 admissions in 1984. Its $2 billion annual budget, which in addition to the acute care hospitals includes five long term care facilities, five neighborhood family care centers, over 30 satellite clinics, and the Emergency Medical Service, would place it on the Fortune 200 of the largest corporations in America were it a publicly held company. In 1984, HHC's bad debt/charity care load was 27 percent of total revenue. I am attaching to this testimony a copy of an article that appeared in Modern Healthcare this spring. It shows that we are not only serving our mission to quality health care for all, but also that we are effectively managing the finances of a complex delivery system.

HHC's acute care facilities will come under the Medicare prospective payment methodology when New York's three year waiver expires on January 1, 1986. HHC considers itself to be New York City's "family doctor." Its guiding principle has been, and remains today, to provide high quality service to all who need it, regardless of their ability to pay. As a result, HHC facilities serve those whose needs are greatest —both medically and financially. From April 1984 to March 1985 Medicaid and Medicare/Medicaid crossover days comprised 56 per cent of total patient days systemwide. By any conceivable standard of measurement, however, we believe all our hospitals to be disproportionate share hospitals.

HHC urges this Committee to implement specific legislation mandating a disproportionate share adjustment. Ideally, we would want such an adjustment to take into account a hospital's bad debt and charity care load, in addition to its Medicaid case load. Although measures using Medicaid only as a proxy are simpler to enact, they exclude from consideration large populations of poor patients who are not Medicaid-eligible, and fail to adjust for facilities such as HHC's that serve all patients, whether they are Medicaid-eligible or not. HHC also proposes that any adjustment, whether based on Medicaid only, or Medicaid

plus bad debt and charity care, not be subject to an arbitrary cap. Although HHC is sensitive to the desire to limit the cost impact of a disproportionate share adjustment, proposals to cap the amount of the adjustment affect those hospitals with the highest proportion of low income and Medicare patients, which are the facilities most in need of special consideration. The Congressional Budget office has shown that there are two thresholds for increased costs per case, occurring at fifteen per cent of low income patients, and fifty five per cent. The second threshold is responsible for a significantly higher cost impact than the first. Measures designed to reimburse a hospital for low-income patient load, up to a set per cent, may fail to account for this second threshold, and thus not adjust for a large part of a hospital's increased costs.

The Congress is to be commended for having foreseen early on that the prospective payment system, without modification, would inadequately compensate disproportionate share hospitals for their higher Medicare costs per case. As Congress recognized, these hospitals typically treat sicker patients with multiple diagnoses who in addition may have delayed their care until the last possible moment. In addition, their patients often require more ancillary services, such as translators, nutritional services, and more extensive discharge planning. All of these factors add to the costs of care in disproportionate share hospitals, and contribute to the inadequacy of payments under the current formula.

These inequities would be compounded by many of the Medicare budget reductions proposals being considered. For example, freezing DRG rates for fiscal year 1986 would result in a loss to HHC in that year of $11.4 million. In addition, since all of HHC's hospitals are teaching facilities, the Administration's proposal to halve the indirect teaching adjustment would cause a $27.1 million loss to HHC in fiscal year 1986 alone. These proposed reductions below the status quo make it all the more imperative that a disproportionate share adjustment be enacted.

Despite the need for an adjustment, however, and despite the mandates included in the Social Security Amendments of 1983, and the Deficit Reduction Act of 1984, as well as the recommendations of the Prospective Payment Assessment Commission (ProPAC), the Administration has refused to implement any disproportionate share adjustment.

The Administration has repeatedly claimed that there is insufficient data to guide implementation of a disproportionate share adjustment. However, studies performed by the Congressional Budget Office (CBO), the American Hospital Association (AHA), and even the Health Care Financing Administration (HCFA) consistently show increased costs for Medicare patients treated in disproportionate share hospitals.

Further, a 1983 study performed by the Center for Health Policy Studies comparing HHC acute care hospitals with a matched group of non-public hospitals clearly showed that patients in the same DRG stay, on an average, over one day longer at HHC facilities than in non-public facilities, with the most important factor in the difference being the percentage of outlier patients. The importance of these studies is clear. They show that the prospective payment methodology, without adjustment, inadequately reimburses disproportionate share hospitals for the costs of caring for their Medicare patients.

By requiring perfect data before implementing any adjustment, however, the Administration is insisting on a standard that was not used in implementing prospective payment, and is certainly not being followed in the numerous freezes and cutbacks now being proposed.

For example, HCFA now admits that disproportionate share hospitals have higher costs per case, but continues to decline to implement an adjustment due to uncertainty over the cause of these increased costs. But this uncertainty has not impeded the Administration from proposing an across the board freeze on DRG rates for fiscal year 1986, regardless of disproportionate share status, and regardless of the cause of their increased costs. Similarly, the Administration has failed to develop a severity of illness index to account for hospitals whose case mix includes more severely ill patients. This, however, has not precluded HCFA from proposing a fifty per cent reduction of the indirect teaching adjustment, which serves as a proxy for severity of illness. A standard of statistical certainty and perfection cannot be required before implementing a disproportionate share adjustment when a substantially lower standard is used for proposals that would adversely affect upon the same hospitals.

The advent of prospective payment has ushered in a new era of health care reimbursement, under which quality care can be provided in a more cost-effective manner. In the development of PPS it was recognized that there would be a need for some "fine tuning" and mid-course corrections along the way. On behalf of HHC I congratulate this committee for its substantial role in the early achievements of PPS, and offer my whole hearted support for measures designed to continue and enhance its success. I believe that a disproportionate share hospital adjustment is a necessary correction that will enhance, rather than impede, the success of PPS. Accordingly, I urge you to support such a measure.

STATEMENT OF TEMPLE UNIVERSITY HOSPITAL

on

PROVISION OF AN ADJUSTMENT

to

MEDICARE PRICES FOR HOSPITALS SERVING A DISPROPORTIONATE SHARE

of

LOW-INCOME AND MEDICARE PATIENTS

Hearing of the Senate Finance Committee
Sub-committee on Health
July 29, 1985

I. BACKGROUND

Temple University Hospital is a 500-bed, non-profit teaching hospital located in an economically depressed area of Philadelphia. The Hospital's dual mission is to train competent medical professionals and to serve the health care needs of Delaware Valley residents. Temple hopes to continue its 93 year tradition of providing high quality primary care services without regard to a person's ability to pay.

As a teaching hospital, Temple provides training in 34 medical and surgical specialties to over 340 resident physicians. Temple conducts important medical research into the causes, prevention and treatment of cancer. It is the leader in the study of thrombosis. Recently, Temple's Heart Transplant Program completed its tenth heart transplant.

Temple's role in serving the poor and providing tertiary care has intensified dramatically with the closing of Philadelphia's public hospital. Each year, Temple provides $10,000,000 in uncompensated care out of an annual operating budget of $100,000,000. With nearly forty percent of its patients covered under Medical Assistance, Temple is the largest provider of indigent care in Pennsylvania and the fourth largest for university owned teaching hospitals in the country.

II. THE PRESIDENT'S PROPOSED BUDGET REDUCTIONS

The Administration has proposed a fifty percent reduction in indirect medical education payments coupled with a freeze on direct medical education reimbursement. Assuming no freeze in the blending rate, Temple Hospital stands to lose $1.5 million in reimbursement. The Hospital has few other resources from which to subsidize this shortfall since only six percent of Temple's patient population pays full hospital charges. Of the remaining 94%, Pennsylvania Medical Assistance (a DRG system not based on the federal model) accounts for 38%, Medicare for 32%, Blue Cross for 14% and the remainder (10%) result in bad debts and under-reimbursed care. Putting it another way, Temple is either at risk, or not reimbursed anything, for all but 6% of its patients. Under these circumstances, even slight changes in Federal or State reimbursement policies have a significant impact on the Hospital's financial well being.

III. NEED FOR CREATION OF A DISPROPORTIONATE SHARE ADJUSTMENT

When Congress passed the legislation implementing the Medicare Prospective Payment System (PPS), it included a provision to reimburse teaching hospitals for a portion of the direct and indirect costs of graduate medical education programs.

This adjustment was created not only to account for the higher costs of these programs, but, in addition, to compensate teaching hospitals for the unmeasured cost factors related to serving indigent patients and those with more complicated illnesses. Congress, by including this adjustment, was giving recognition to the very necessary function performed by teaching hospitals in the United States.

By their nature, teaching hospitals attract the more severe, complicated illnesses that other hospitals are unable to treat. Due to their location (usually large urban areas) they treat more patients who are unable to afford the cost of health care. Should Congress decide to reduce indirect medical education payments, it is critical that a disproportionate share be developed to compensate hospitals for costs that are beyond their control.

The Department of Health and Human Services itself recognized the importance of the Indirect Medical Education Adjustment when it suggested doubling the adjustment after a Congressional Budget Office study showed that under the proposed DRG's, 71% of the teaching hospitals would be adversely affected. It would truly be unfair for Congress to now allow the Administration to reduce this adjustment, without making provision to deal with the problems the adjustment was meant to alleviate.

IV. TEMPLE UNIVERSITY HOSPITAL'S PERFORMANCE UNDER PROSPECTIVE PAYMENT

Temple University Hospital has enthusiastically accepted the opportunities presented by the Prospective Payment System. There is ample evidence of Temple's commitment to bringing health care costs under control. The average length of a patient's stay at Temple has decreased by 17% (from 9 to 7.6 days); this is 5-10% below the average length of stay of other area medical school hospitals. Temple has done more than hold the line on expenses; expenses increased 11% less over the past three years than at other area hospitals. For the first six months of fiscal year 1985, Temple's expenses increased only 2%, significantly less than the 4.8% average increase for other area hospitals.

Temple's patients are generally poorer and sicker than the national average. The Hospital's Case-Mix Index (which measures clinical intensity of a hospital) is 1.1875, as compared with a national average of 1.0; a clear indication that Temple is caring for sicker patients with more severe diagnoses. Recent studies conducted at the Hospital revealed that 65% of all patients admitted to Temple require special nutritional assistance of some form. Fifteen percent (15%) of the patients screened were considered malnourished and required extra oral supplementation, tube feeding, percipheral parenteral nutrition or total parenteral nutrition. It is a fact that

malnutrition affects mortality, morbidity and length of hospital stay. The Hospital incurred approximately $425,000 in additional cost to treat patients suffering from malnutrition.

A good indicator of the acuity level of a hospital's patient population is the number of admissions that become classified as outliers. At Temple, 2.3% of the Medicare patients admitted become cost outliers, a percentage that greatly exceeds the government's expected average of 0.9% of Medicare admissions. Day outlier cases for both Medicare and Medicaid are below the government's expected average as evidenced by the Hospital's decreased length of stay. The total unreimbursed cost incurred by the Hospital in connection with cost outlier cases is approximately $450,000 per year. In summary, Temple is treating more costly, complex cases than the national average.

As an inner city hospital, Temple incurres additional costs, not reflected in the national DRG rates, that place it at a distinct disadvantage in relation to suburban hospitals. Temple must pay higher wages to attract and retain competent personnel. Since the Hospital is located in a high crime area, security costs are significantly higher than normal.

Temple has a problem with overstay patients. These are patients who cannot be discharged from the hospital because they need the services of a nursing home or home health care. The Hospital's social work department spends much of its time trying to place these patients. It is a difficult and frustrating task, since there is a shortage of nursing homes willing to take Medicaid patients. Since these patients no longer need hospital care, Temple receives no further reimbursement, although the Hospital must continue to care for the patient until a nursing home bed is located. Overstays cost Temple approximately $1.1 million last fiscal year and the problem is increasing under DRG's.

V. CHOICE OF A PROXY FOR LOW-INCOME CARE

Temple supports the use of all Medicaid patients, not just dual eligibles, as a proxy for low income care. Various studies have shown that hospitals serving a large percentage of low income patients have higher Medicare costs per case. The traditional method used by hospitals to deal with this problem has been to shift costs to other payors. With Temple's patient mix, this is not a viable alternative.

Several interested parties have noted that inclusion of all Medicaid patients presents some theoretical problems, given the state-to-state variation in programs. These problems are not insurmountable and should not be allowed to act as a roadblock to needed reform.

The Prospective Payment System is replete with assumptions, averages and projections, some having better empirical support than others.

VI. CONCLUSION

It is our hope that this information will help the Committee during its deliberations on this important issue. With pressures building to reduce the federal deficit, the government must not lose sight of the public mandate that calls for equal access to quality healthcare for all citizens. This access is imperiled without a disproportionate share adjustment to help alleviate the increased burdens of the nation's teaching hospitals. We are willing to work with the Committee to develop an equitable adjustment.